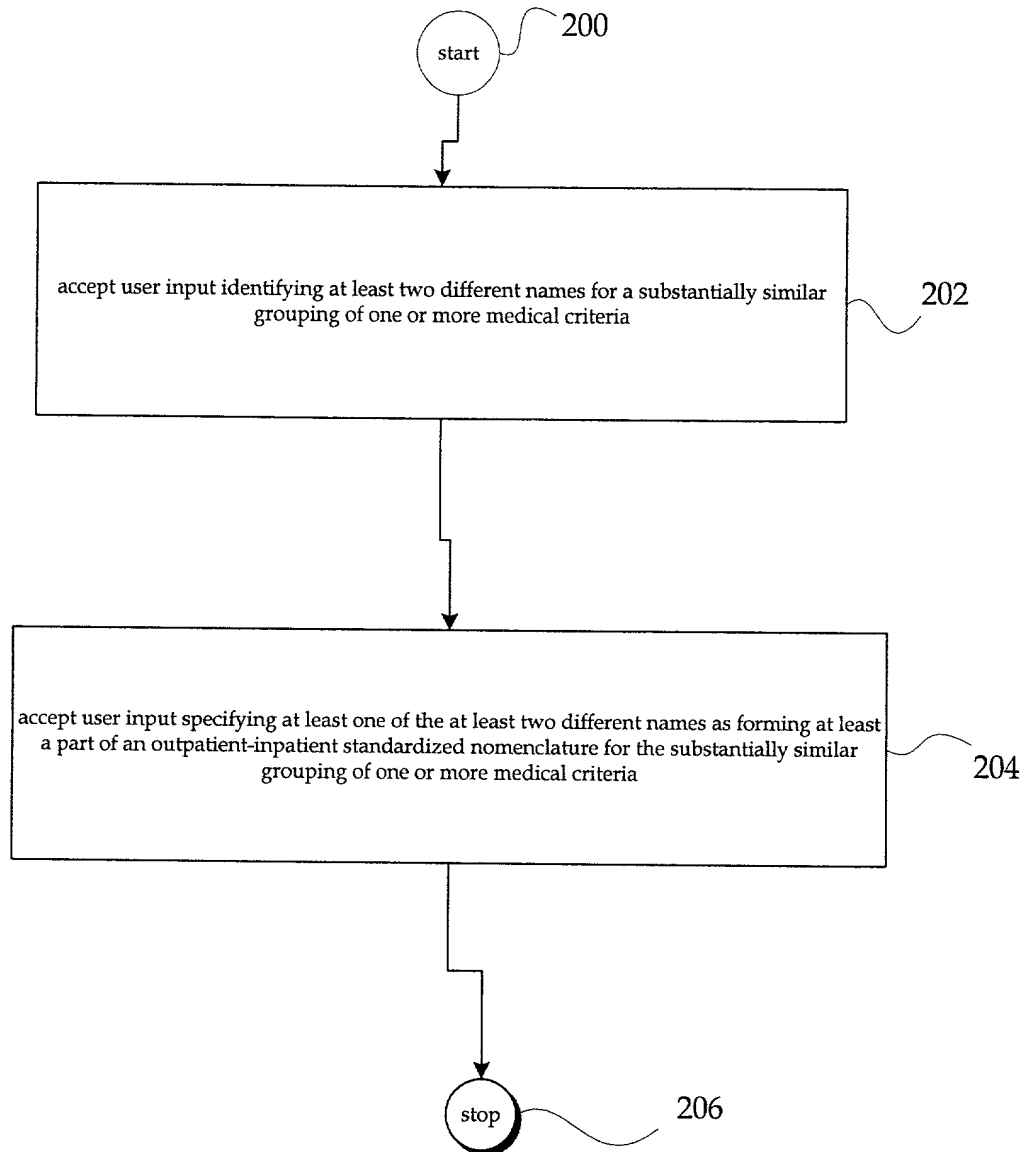
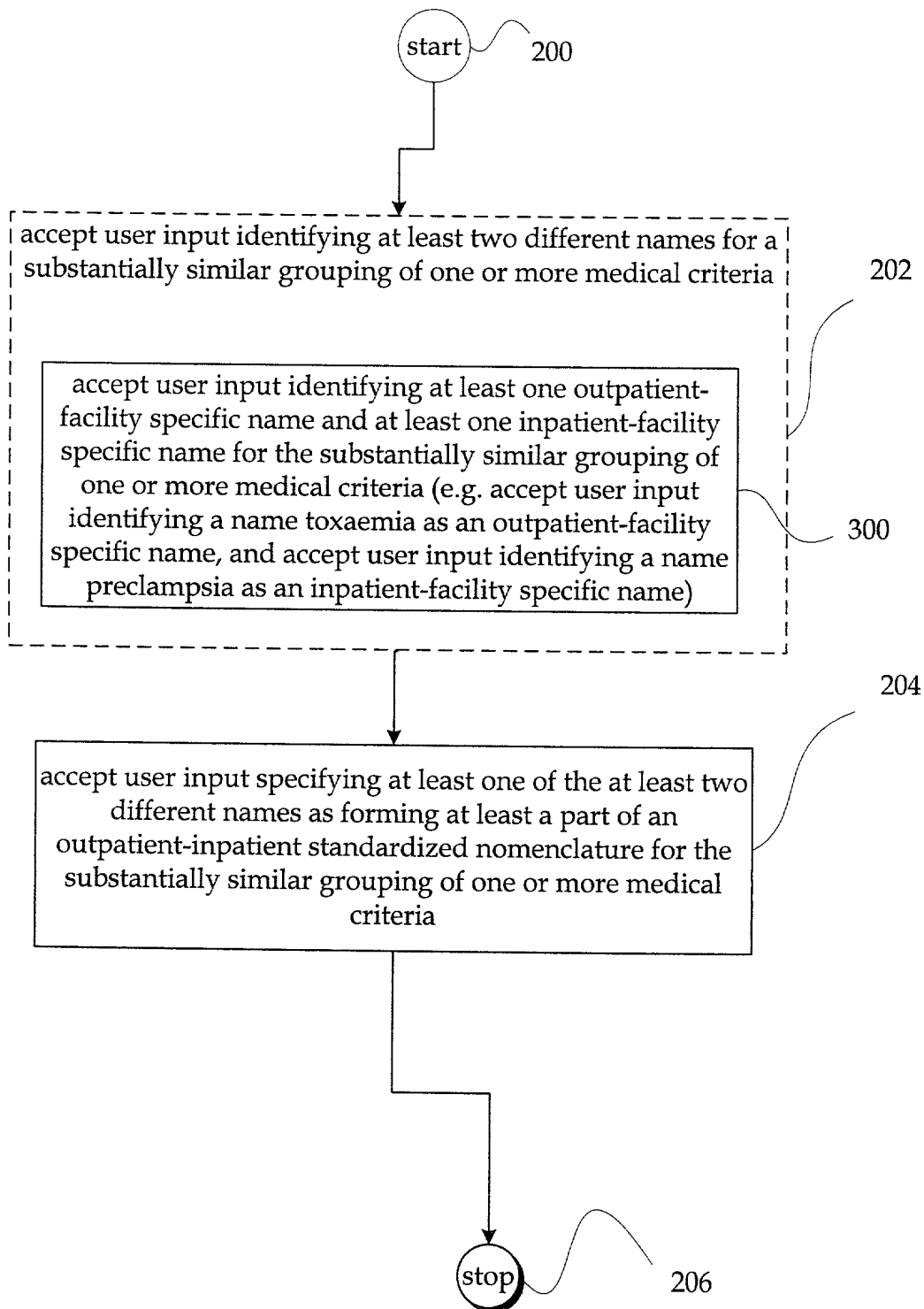
**Fig. 1**

*Fig. 2*

*Fig. 3*

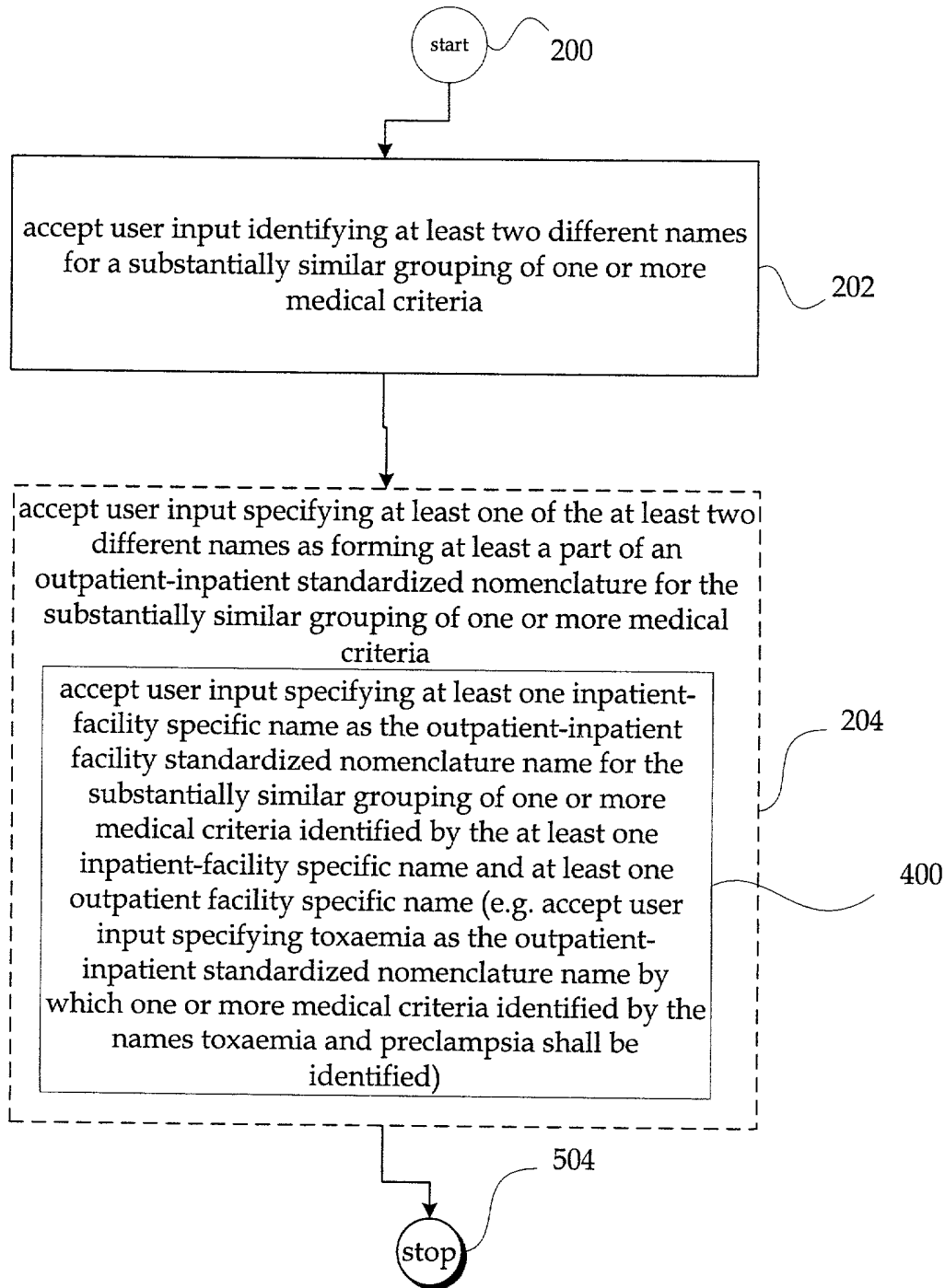


Fig. 4

5/55

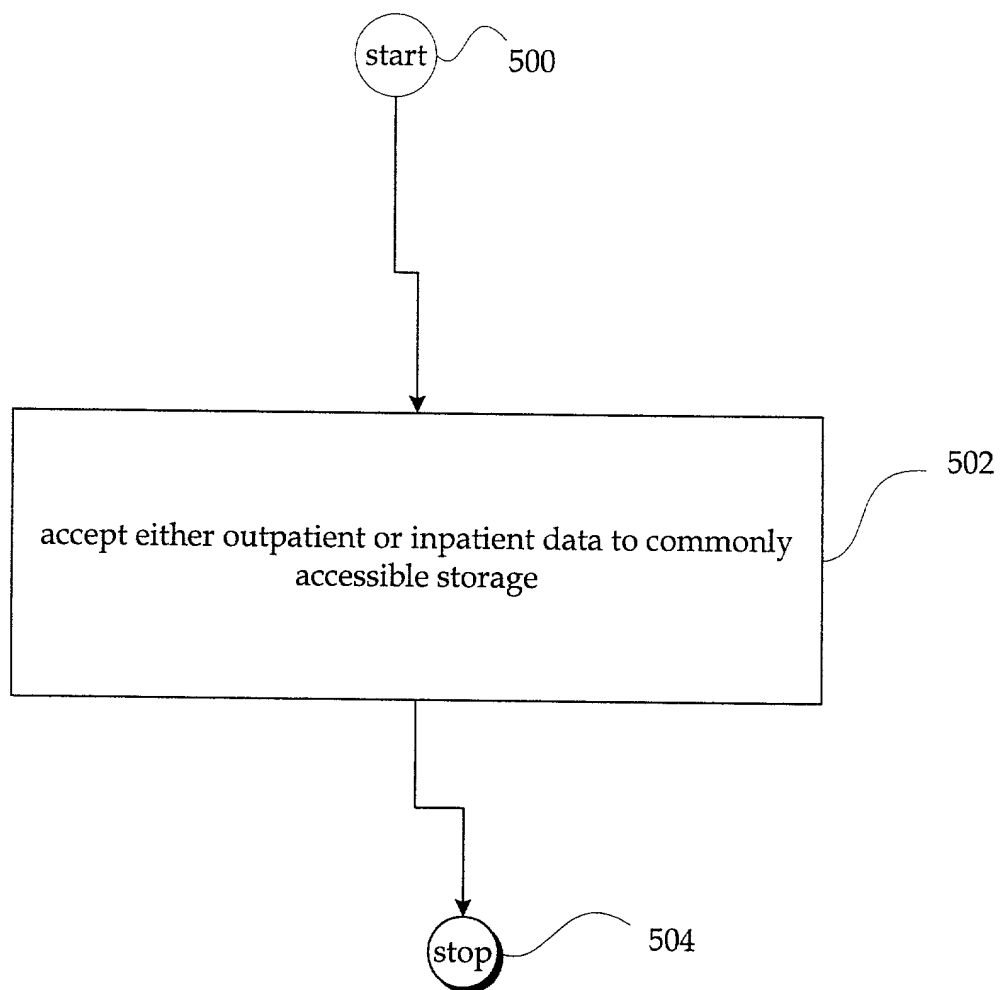
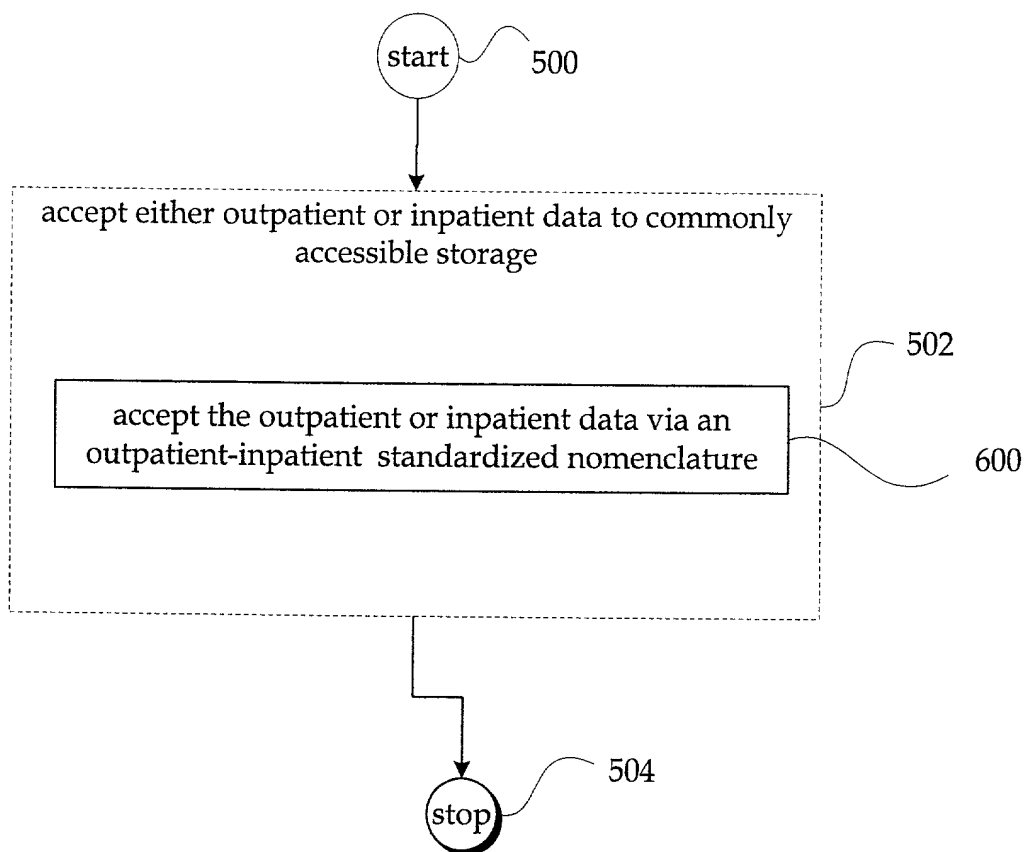


Fig. 5

*Fig. 6*

7/55

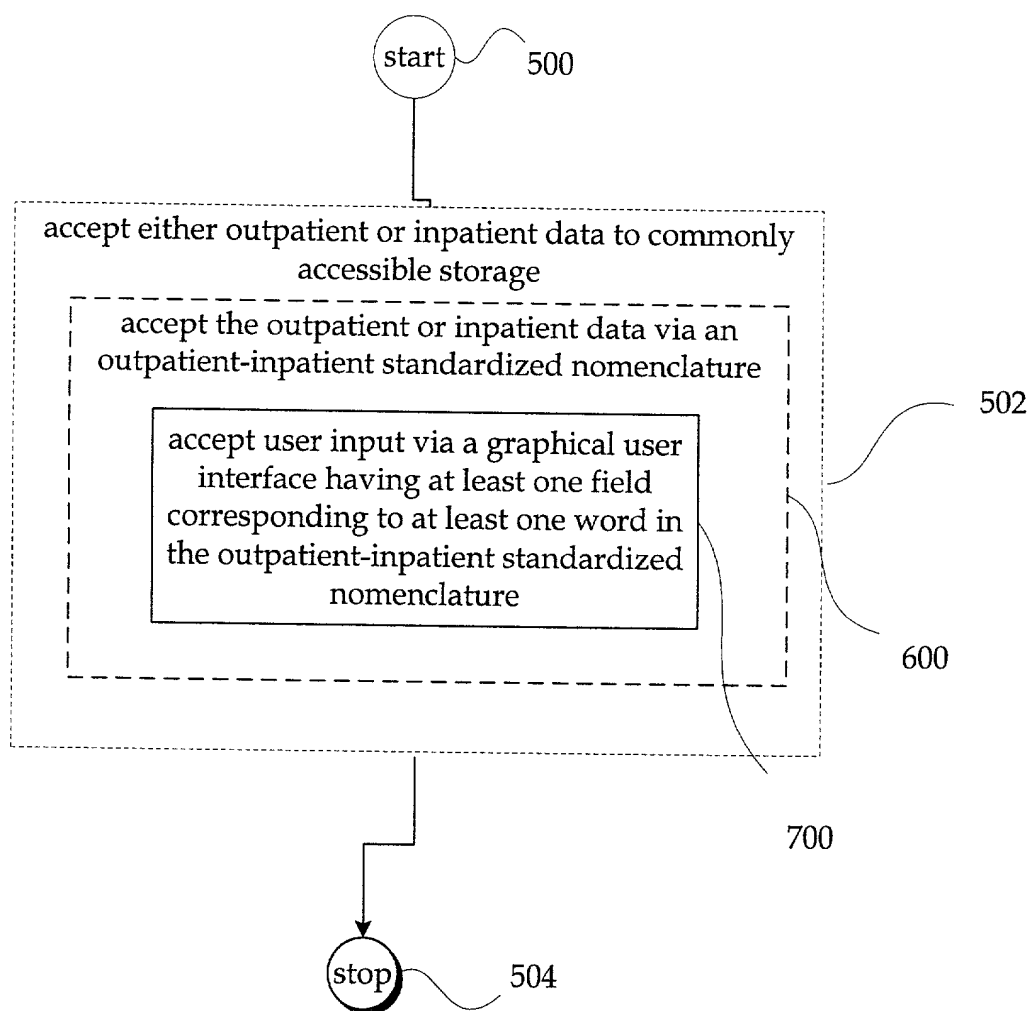


Fig. 7

STORC - Standard Obstetrics Record Charting System ***** TRAINING DATABASE *****

File View Tools Windows Help

Functional Area: OB Clinic

Key Info General Visits Physical History Cerv Exams Demo Tests US Procs Meds Compl Pb List Notes

History for Patient Name; Patient SSN Disposition: **DELIVERED**

COMPLICATED Age: 38 G/P: 5/1-1-3-2 EDC: 30 Jul 1999 Gest Age: 38 4/7 Type/Rh: A- **STD LABS** **NKDA**

Assoc Visit/Encounter: **ADMISSION** 20 Jul 1999 1610 **History Information** SF533 History/Physical Data Reviewed By/Date: **drmann** 21 Jul 1999 1801

PMH/PSH DB Hx Family/Social/Subst Hx Allergies/Menstrual Hx ☐ SF533 is/will NOT be entered in STORC **Next**

☒ Conditions for all other history categories, not listed below, are normal. Note: PMH, PSH and the remarks data will carry over from past pregnancies.

Past Medical Condition(s)	Pb List?	Plan for Pb List	Resolved?	Comment
ASTHMA	<input type="checkbox"/>		<input type="checkbox"/>	since birth, on azthmacort inhaler
PELVIC INFLAMMATORY DISEASE	<input type="checkbox"/>		<input checked="" type="checkbox"/>	in 1995 Treated successfully with xxx
CONDYLOMA, VAGINAL	<input type="checkbox"/>		<input type="checkbox"/>	
CONDYLOMA, VULVAR				
CONSTIPATION				
CONSTIPATION, CHRONIC				
COPD PULMONALE				
CORONARY ARTERY DISEASE				
CORRECTIVE LENSES				
COSTROCONDRIITIS				
CROHN DISEASE (REGIONAL ENTERITIS)				
CYSTITIS, SPECIFY				
DEEP VENOUS THROMBOSIS, PRIOR PREGNANCY				
DEEP VENOUS THROMBOBSIS, NOT PREG RELATE				

Add **Delete**

Pb List? Plan for Pb List Comment

Add Surg **Delete**

New Remarks (dbl click for more) Prev Remarks

☒ Mark SF533 History and Physical Data Reviewed/Save/Close **Save/Close** **Save** **Cancel** **Reset** **Help**

Office **Microsoft**

Start **ST...** 2:53 PM

Fig. 7A

9/55

STORC - STandard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Stages of Labor and Delivery for BOND Patient Name: Patient SSN Position: DELIVERED-CURRENT

COMPLICATED Age: 35 5/P 1/0/0/0 EDC: 06 Dec 2001 Gest Age: 38 0/7 Type/Rht: A+ STD LABS NKDA

Entered: drcho 23 Nov 2001 1813 Labor and Delivery Information Reviewed: drmann 24 Nov 2001 0456

First Stage and Medication Info Second and Third Stages Other Procedures Other Complications

General Information

Prior C-Section? ☐ N Vaginal Birth Candidate? ☒ Y

First Stage

Onset Date: 23 Nov 2001 Time: 0630

Progress: AUGMENTED

Duration: 9hr 8min

Augmentation

☒ Oxytocin Augmentation?

Duration of Oxytocin: 6 hr 20 min

Highest Dose: 9

Enter Other Medications Given During Labor/Delivery:

Analgesia

Analgesia	Date (mm/dd/yyyy)	Time	Add	Delete
FENTANYL	23 Nov	2001	Add	Delete

Anesthesia

Anesthesia	Date (mm/dd/yyyy)	Time	Add	Delete
INTRATHECAL ANESTHESIA	23 Nov	2001	Add	Delete
EPIDURAL	23 Nov	2001	Add	Delete

Induction

Induction Type	Date (mm/dd/yyyy)	Time	Add	Delete
NO INDUCTION	23 Nov	2001	Add	Delete

SVD Op Vag C Sect

☒ Mark Reviewed/Save/Close Save/Close Save Cancel Delete Reset Help

Office

Start Sid Inb CD Inb CH CH FW RE Mic S

2:21 PM

Fig. 7B

ATTORNEY CLIENT PRIVILEGED AND/OR CONFIDENTIAL

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl PbList Notes

Stages of Labor and Delivery for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 0/7 Type/Rht: A+ **STD LABS** **NKDA**

Entered: drcho 23 Nov 2001 1813 **Labor and Delivery Information** Reviewed: drmann 24 Nov 2001 0456

First Stage and Medication Info Second and Third Stages Other Procedures Other Complications

Second Stage

Onset Date: 23 Nov 2001 Time: 1538 Duration: 1 hr 12 min

Episiotomy: MIDLINE EPISIOTOMY Date (mm/dd/yyyy): 23 Nov 2001 Time: Add Epis Delete

Laceration: NO LACERATION Date (mm/dd/yyyy): 23 Nov 2001 Add Lacer Delete

Sutures: 2-0 VICRYL SUTURE 2-0 CHROMIC SUTURE

Repair: REPAIR OF LACERATION/EPISIOTOMY IN THE USUAL FASHION

Skin Prep: BETADINE Hospital/Location: LRMC

Newborn Information:

Wt (gm)	Sex	Delivery Type/Outcome	Liveborn?	Neo Death?
3560	FEM	VAGINAL DELIVERY	Y	N

Add Update Delete

Third Stage (Placenta)

Onset Date: 23 Nov 2001 Time: 1650

Plac. Deliv: SPONT DELIVERY OF PLACENTA

Deliv. Date: 23 Nov 2001 Time: 1656

Appearance: INTACT & NORMAL

Vessel: 3 VESSELS

☐ True Knot ☐ Velementous Insertion

Duration: 0 hr 6 min

Summary and Delivery Comment

EBL: 300 ml Dur of Rupture: 12 hr 50 min Dur Total: 10 hr 25 min

SVD Up Vag C-Sept

Mark Reviewed/Save/Close Save/Close Save Cancel Delete Reset Help

Office

Start Stop Inb CD Inb CH CH FW RE Mic Gs 2:21 PM

Fig. 7C

11/55

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Stages of Labor and Delivery for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/F 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 0/7 Type/Rh: A- STD LABS NKDA

Entered: drcho 23 Nov 2001 1813 Labor and Delivery Information Reviewed: drmann 24 Nov 2001 0456

First Stage and Medication Info Second and Third Stages Other Procedures Other Complications

List of Common Delivery Procedures

- AMNIOINFUSION
- ANTIBIOTICS, IV
- FETAL SCALP ELECTRODE
- FOLEY PLACEMENT
- INJECTION, ANTIBIOTICS
- INJECTION, RH IMMUNE GLOBULIN
- IUPC PLACEMENT
- POSTPARTUM TUBAL LIGATION
- REPLACE EPIDURAL
- TRANSFUSION, BLOOD EXPANDERS
- TRANSFUSION, FRESH FROZEN PLASMA
- TRANSFUSION, PACKED RED BLOOD CELLS
- TRANSFUSION, PLATELETS

Add Selected Procedure for Patient

Current List of Other Procedures for Selected Patient

Procedure	Date	Time	Perf
FETAL SCALP ELECTRODE	23 Nov 2001	1350	
FOLEY PLACEMENT	23 Nov 2001	1410	

Refresh List Enter Additional Procedures

SVD: Op Vag: C- Sect

Mark Reviewed/Save/Close Save/Close Save Cancel Delete Reset Help

Office

Start Sid... Inb... CD... Inb... CH... CH... FW... RE... M... S...

2:22 PM

Fig. 7D

12/55

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Stages of Labor and Delivery for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age 35 G/P 1/0-0-0-0 EDC 06 Dec 2001 Gest Age 38 0/7 Type/Rh A+ STD LABS NKDA

Entered: drcho 23 Nov 2001 1813 Labor and Delivery Information Reviewed: drmann 24 Nov 2001 0456

First Stage and Medication Info Second and Third Stages Other Procedures Other Complications Next

List of Common Delivery Complications

- BLADDER INJURY
- BOWEL INJURY
- CARDIOPULMONARY ARREST, NOT RESUSCITATED
- CARDIOPULMONARY ARREST, RESUSCITATED
- EXTRAUTERINE PREGNANCY (EUP)
- HEMATOMA, VAGINAL
- HEMATOMA, VULVAR/PERINEAL
- HEMORRHAGE
- INDUCTION OF LABOR, FAILED - SPECIFY
- INDUCTION OF LABOR, MECHANICAL - FAILED
- MATERNAL MORTALITY
- MULTIPLE GESTATION WITH MALPRESENTATION
- MULTIPLE GESTATION, LOSS OF ONE OR MORE

Add Selected Complication for Patient

Current List of Other Delivery Complications for Selected Patient

Delivery Complication for Mother	Comment
----------------------------------	---------

Refresh List Enter Additional Complications

SVD: Dp Veg: C Sect

Mark Reviewed/Save/Close Save/Close Save Cancel Delete Reset Help

Office

Start Sid... Inb... CD... Inb... CH... CH... PW... RE... Mic... 2:22 PM

Fig. 7E

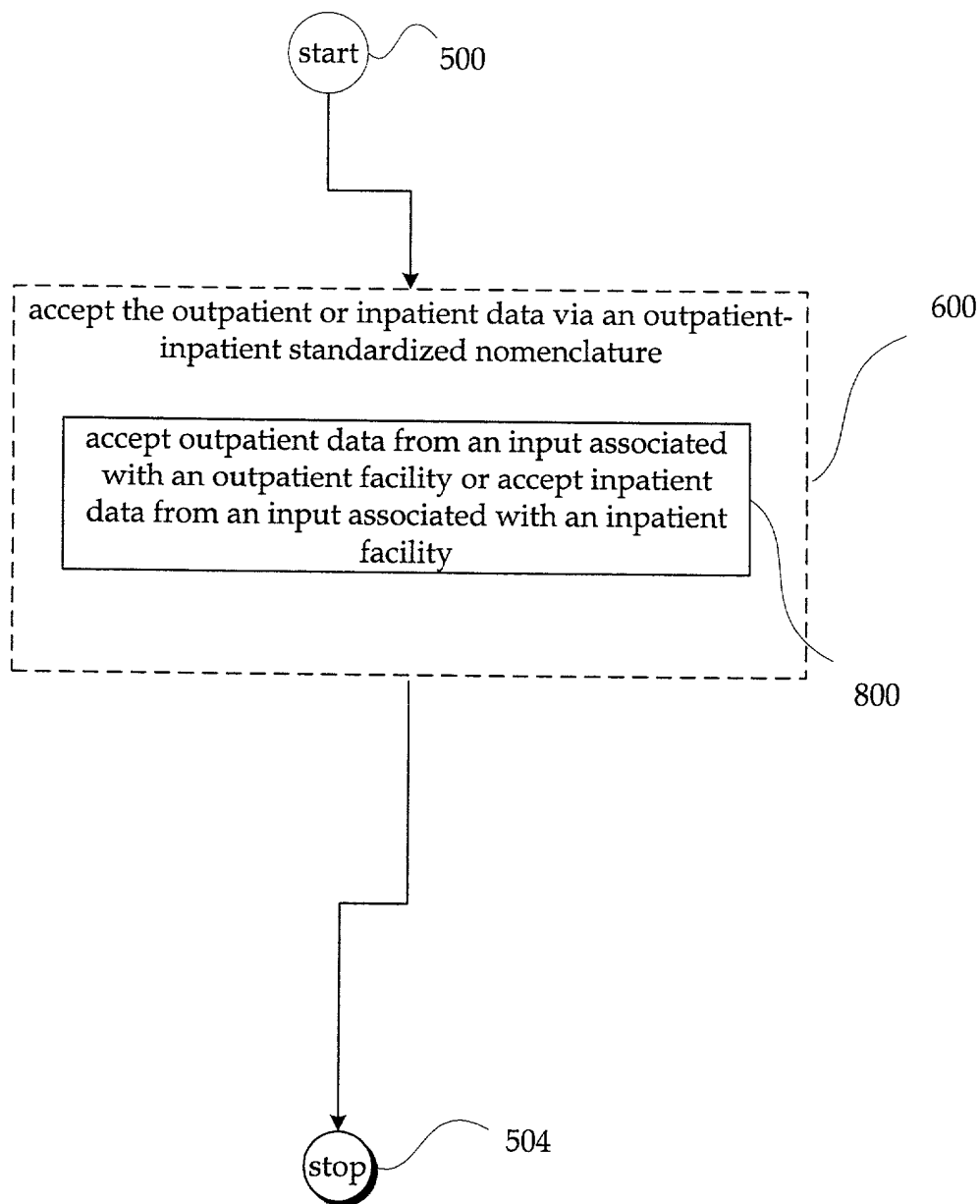


Fig. 8

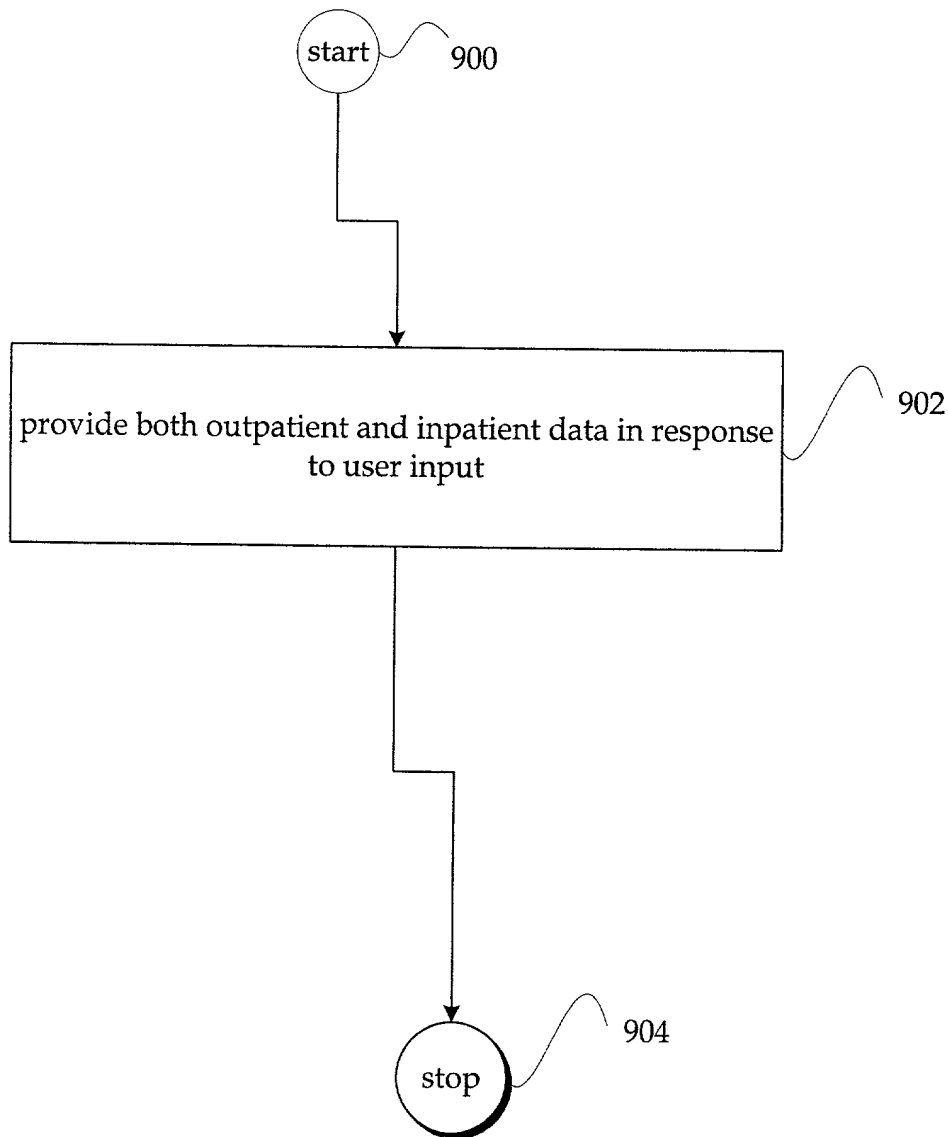


Fig. 9

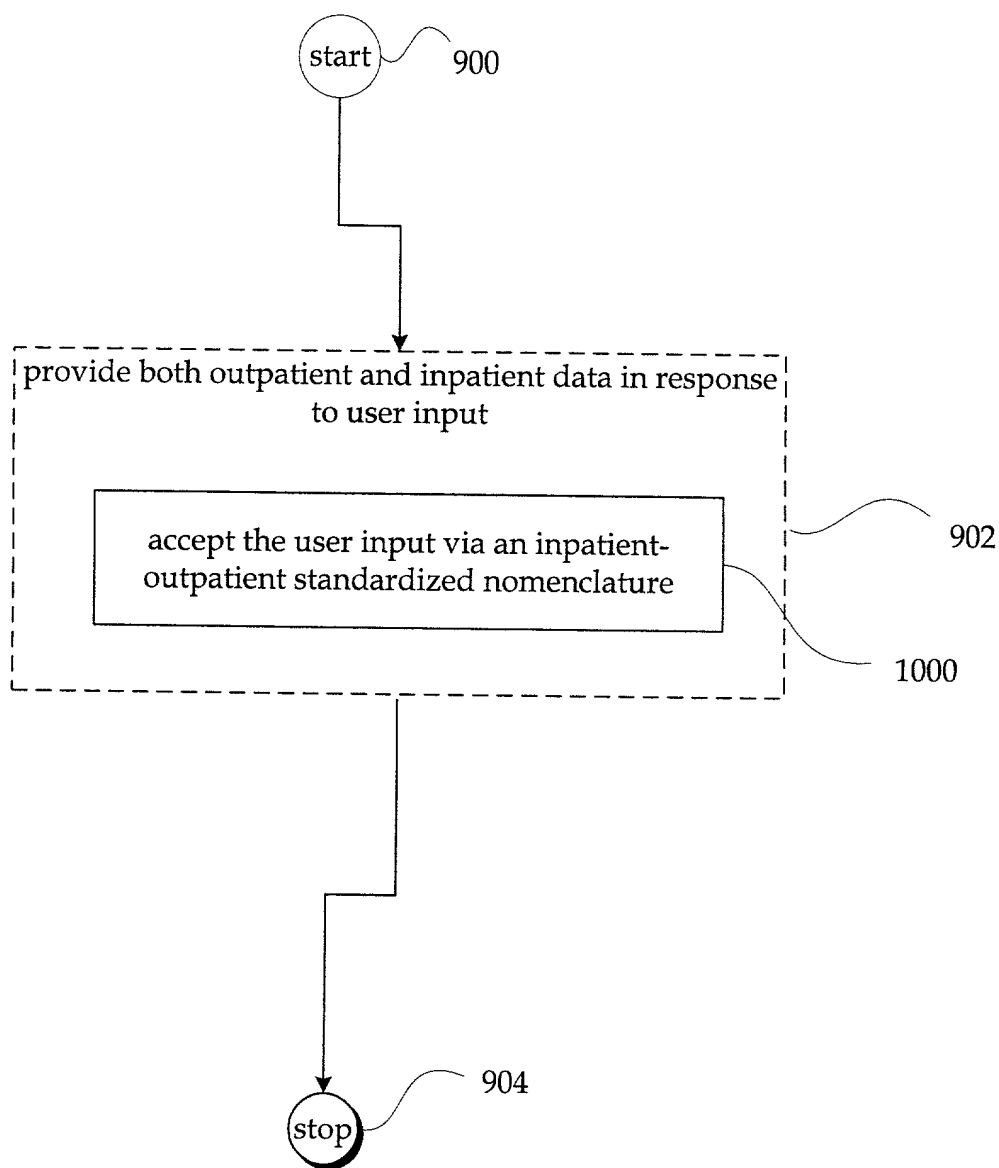


Fig. 10

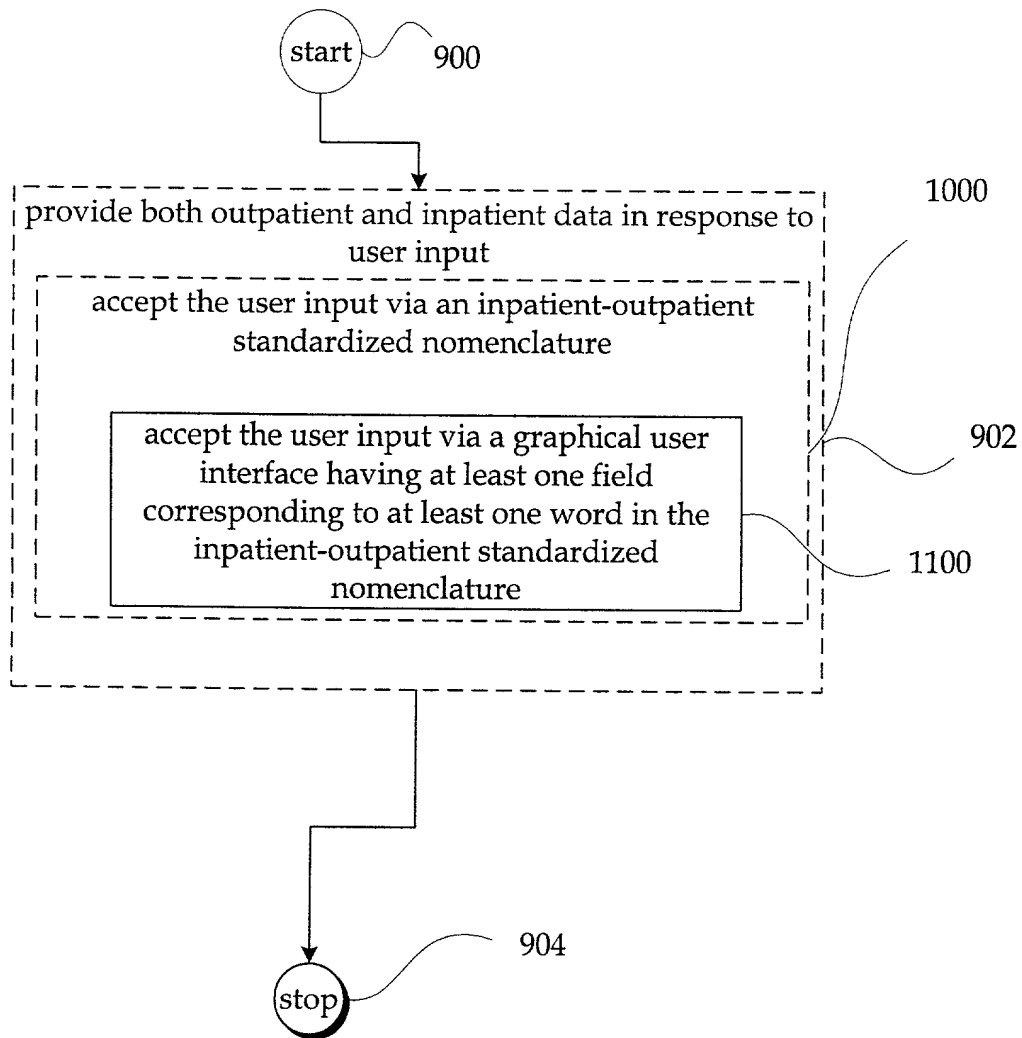


Fig. 11

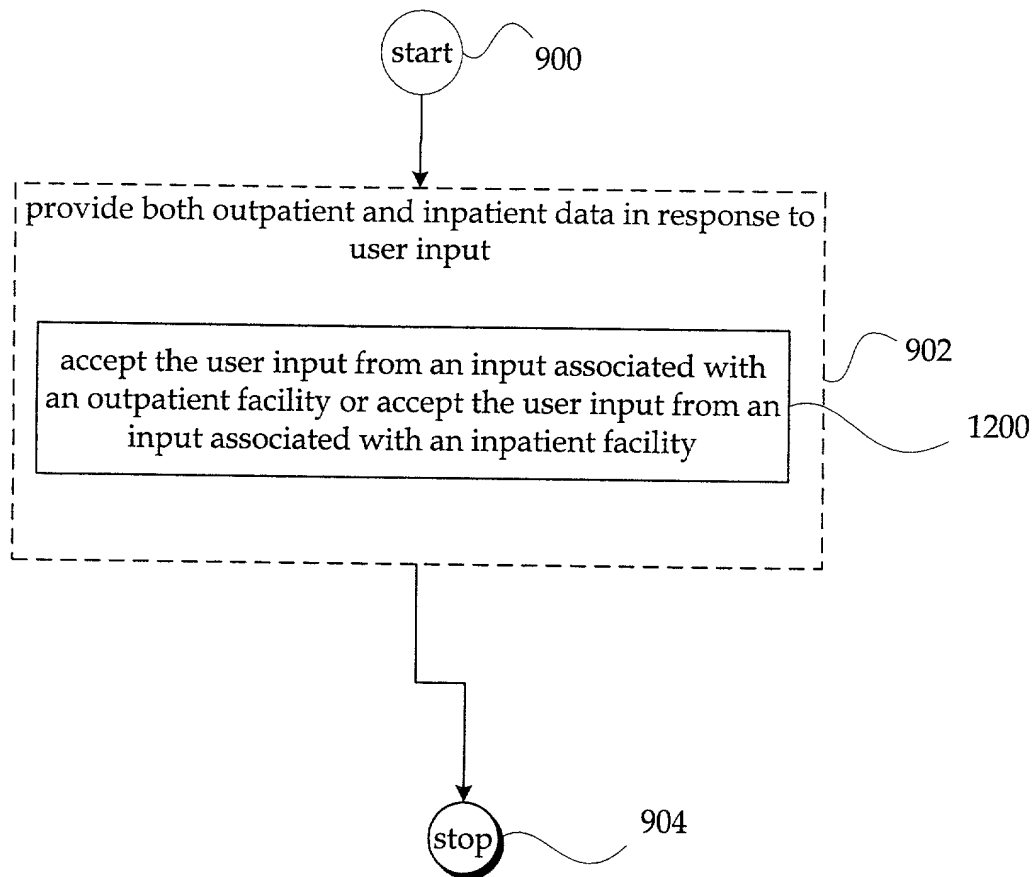


Fig. 12

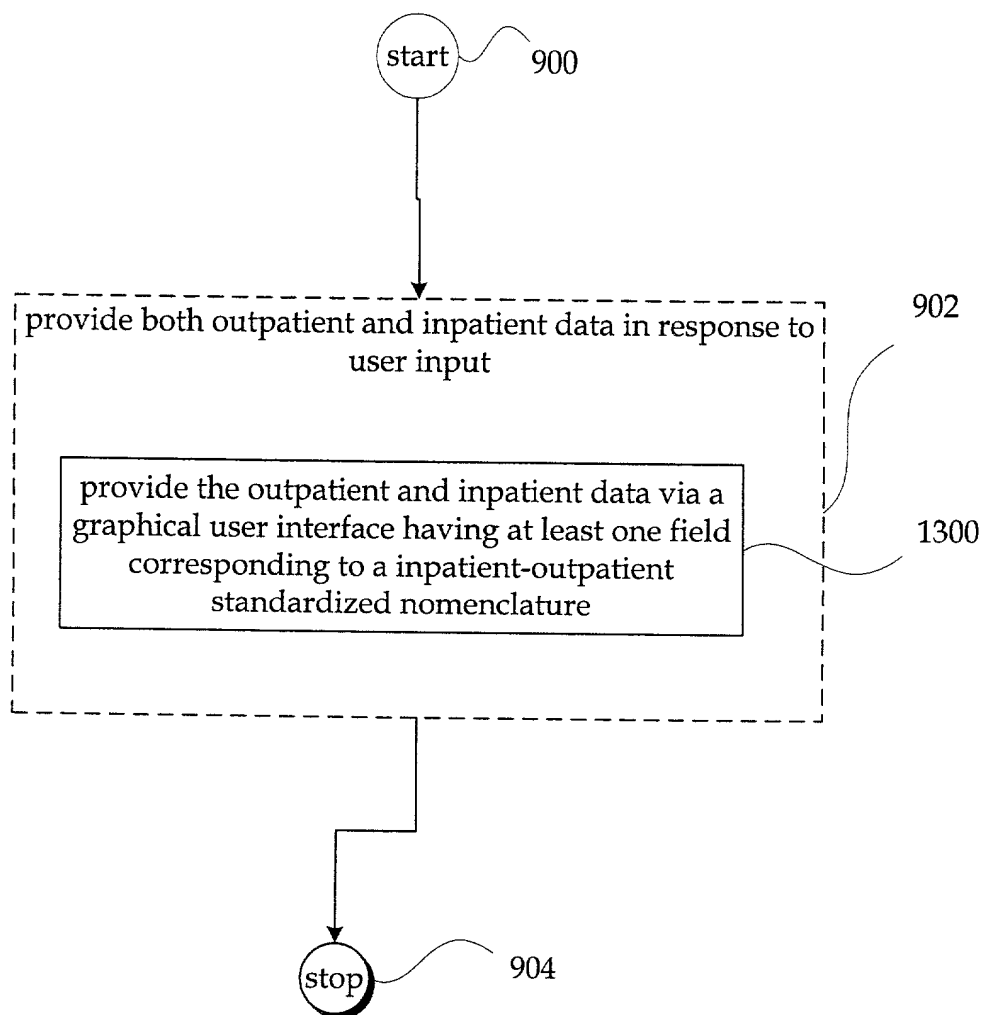


Fig. 13

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: OB Clinic

Key Info General Visits Physical History Cerv Exams Demo Tests US Procs Meds Compl Pb List Notes

Key Information for Patient Name; Patient SSN **Disposition: PREGNANT**

UNASSIGNED Age: 26 G/P: 3/0-0-2-0 EDC: 16 Dec 2001 Gest Age: 38 0/7 Type/Rh: O- **STD LABS ALLERGIES**

Notes Labs Phone Consult Print **Key Information** All Pbs Major Minor Row Height: 100

Problem List (R - Resolved)

Problem/Condition	Plan (Double click in field to see entire plan)	Comment	Date
ASTHMA	on Alupent/Azthmacort inhaler pm		02 C
LATEX ALLERGY	delivery at LRMC	associated with RASH	02 C
OTHER, SPECIFY		Pt reports allergy to PCN, Tetracycline, Sulfa,	25 C
OVARIAN MASS CYSTIC, SPECIFY	L - 9 cm simple cystic mass- transfer from	delivery at LRMC	02 C
RH NEGATIVE			25 C
SEIZURE DISORDER, OTHER	Not active	CHILDHOOD ILLNESS	02 C

Allergies

Allergy Name	Comment
CLINDAMYCIN	swelling
LATEX	

Current/Prior Admissions **Current Meds (not available yet)**

Surgical History

Surgical Procedure	Comment

Social/Substance History

Social/Substance Condition	Comment

Note: If some items are not listed and they should be, make sure you have saved all changes on all open screens and then click Refresh. Use the Windows menu option to view a list of open screens.

Office [Icons] [Close] [Refresh] [Help]

Start Slide Sh. CHCS CHCS Inbox STORC RE: Left Microso...

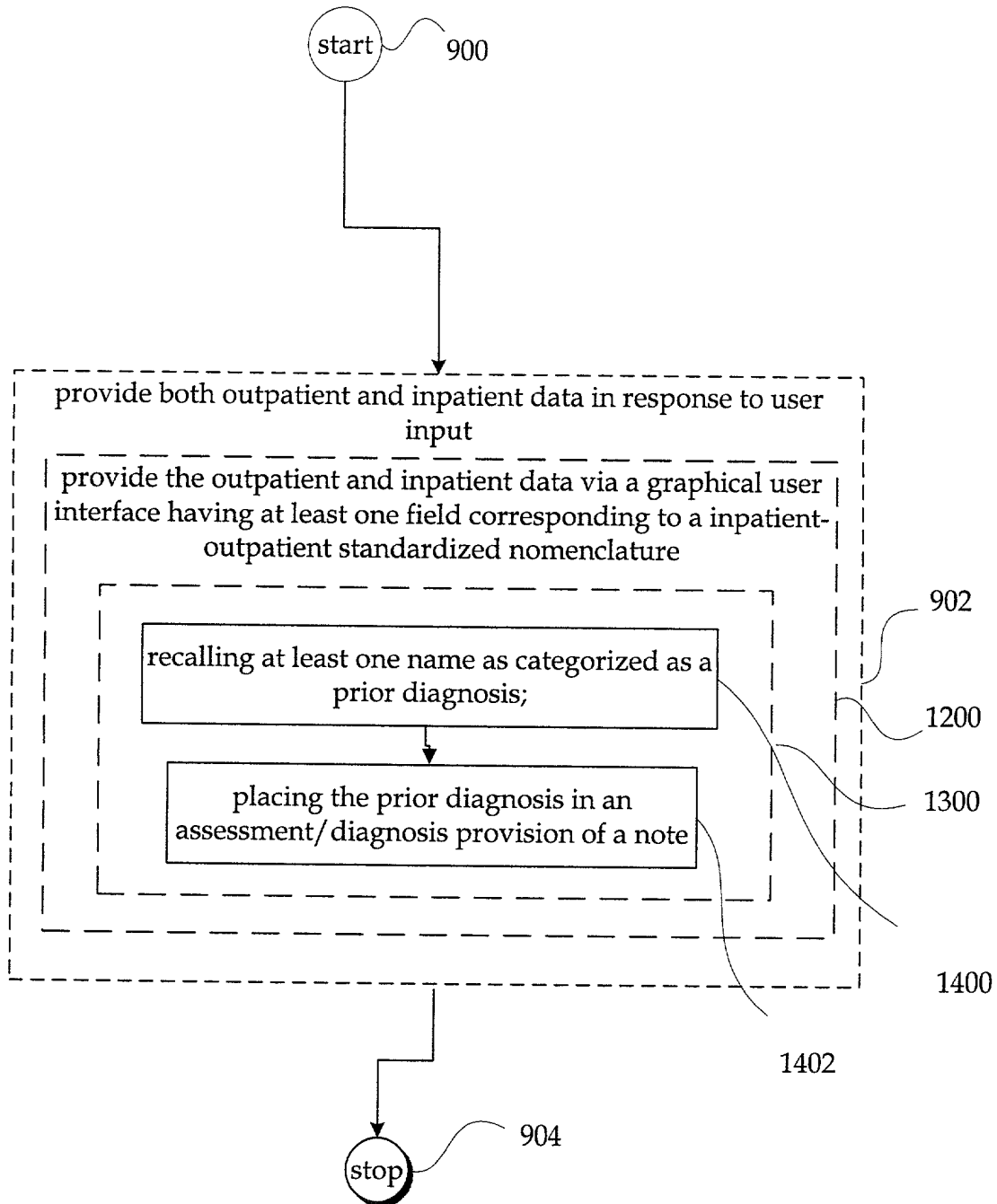
6:35 AM

1352

1354

1350

Fig. 13A

*Fig. 14*

STDRC - Standard Obstetrics Record Charting System TRAINING DATABASE

File View Tools Windows Help

Functional Area: OB Clinic

Key Info General Visits Physical History Cerv Exams Demo Tests US Procs Meds Compl Pb List Notes

ROB/COB Detailed Visit Information for Patient Name; Patient SSN Disposition: DELIVERED

COMPLICATED Age: 38 G/P: 5/1-1/3-2 EDC: 30 Jul 1999 Gest Age: 38 4/7 Type/Rh: A- STD LABS NKDA

Detailed OB Visit Information

Subjective Objective Assessment/Plan ROB Visit COB Visit Next

Assessment

Assessment (Health Condition/Diagnosis)	Pb List?	Plan (Dbl Click)	R/O?	Comment	Add	Delete
LATEX ALLERGY	<input type="checkbox"/>		<input type="checkbox"/>			
ROB, UNCOMPLICATED	<input type="checkbox"/>		<input type="checkbox"/>			

ROB COB

Patient Specific Assessments:

Plans

Standard Plan/Remark	Entered By	Entered Date	Del
Standard Plan for >= 41 wks	drmann	30 Nov 2001 1500	

Add Plan Delete Std

Patient Specific Plan(s): Labor Precautions, Daily Fetal Kick Counts recommended, RTC in 1 week, NST/AFI 2x/wk, Consider induction

CHRONIC CONDITIONS WERE ADDED View Existing Notes OK Cancel Reset Help

Office

Start Slide Inbo CD Inbo CHC CHC FW RE Microsoft Word - Document5 2:46 PM

Fig. 14A

22/55

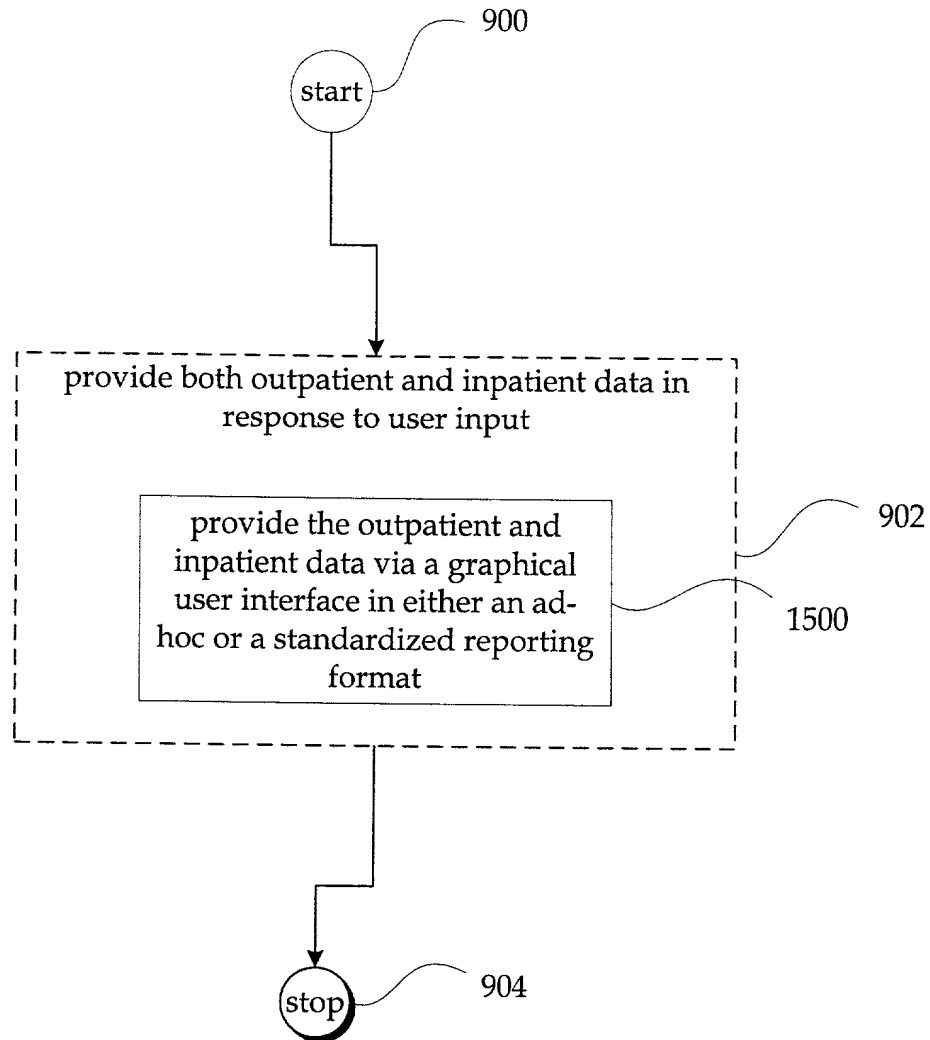
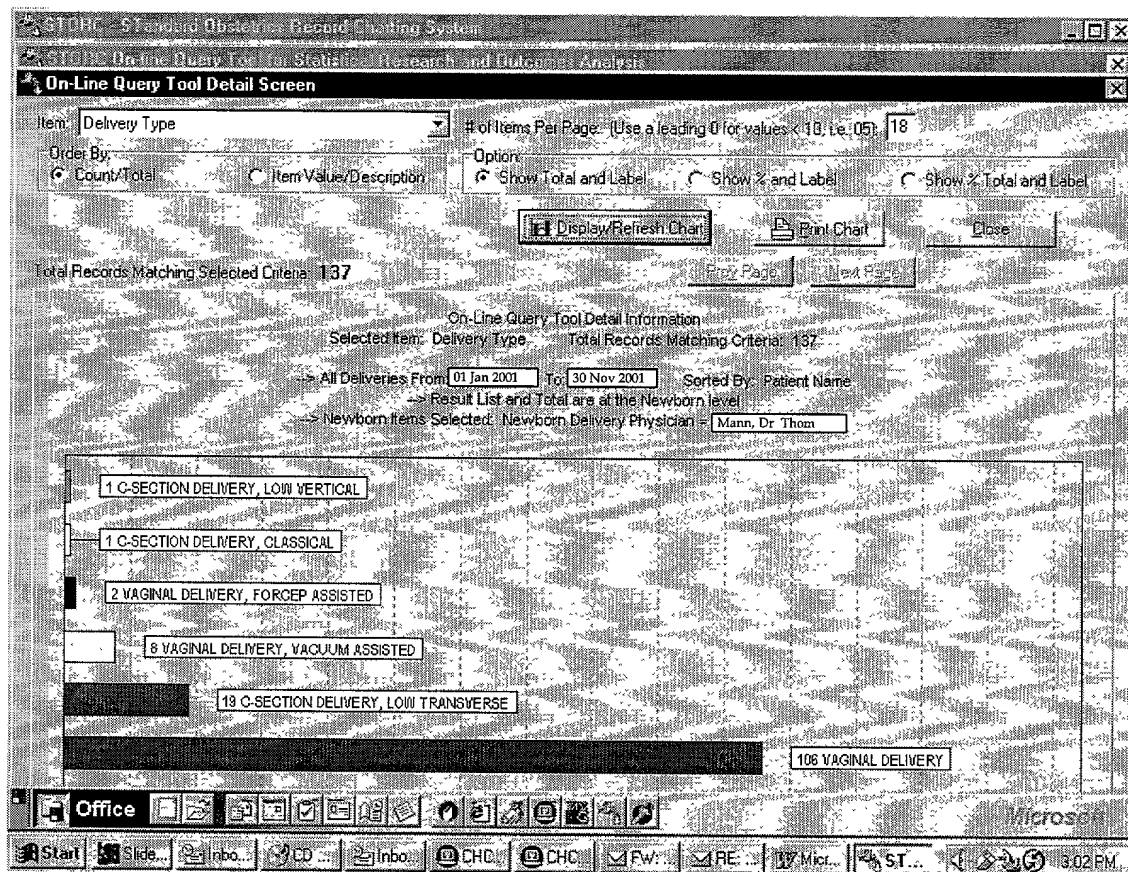


Fig. 15



1550

1552

Fig. 15A

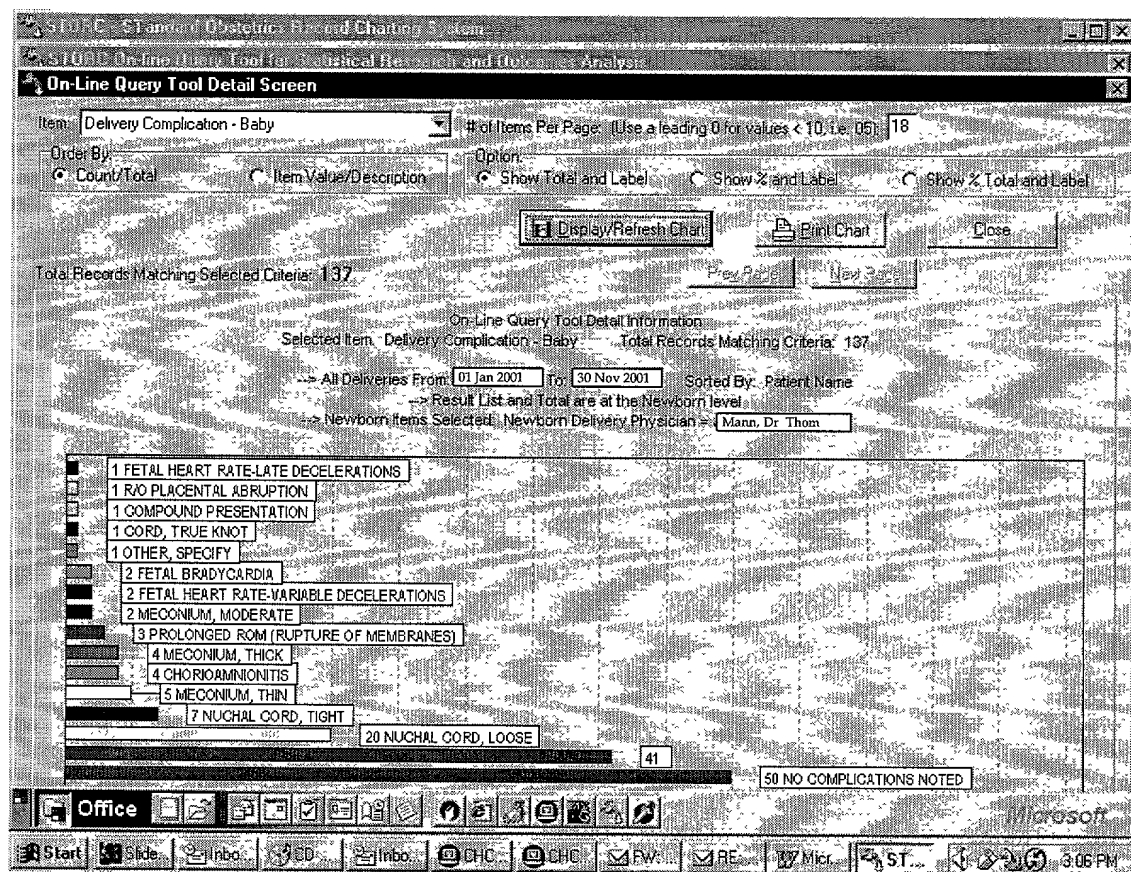
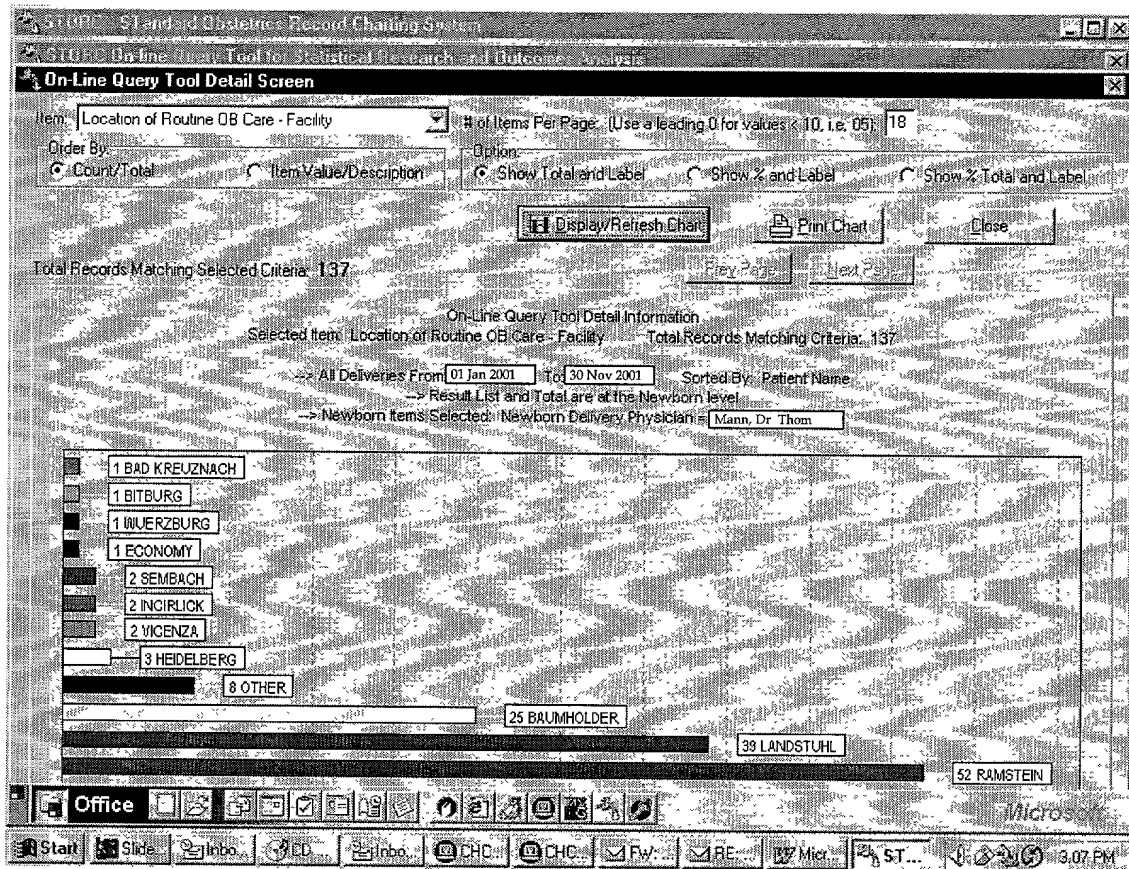


Fig. 15B



1580

1582

Fig. 15C

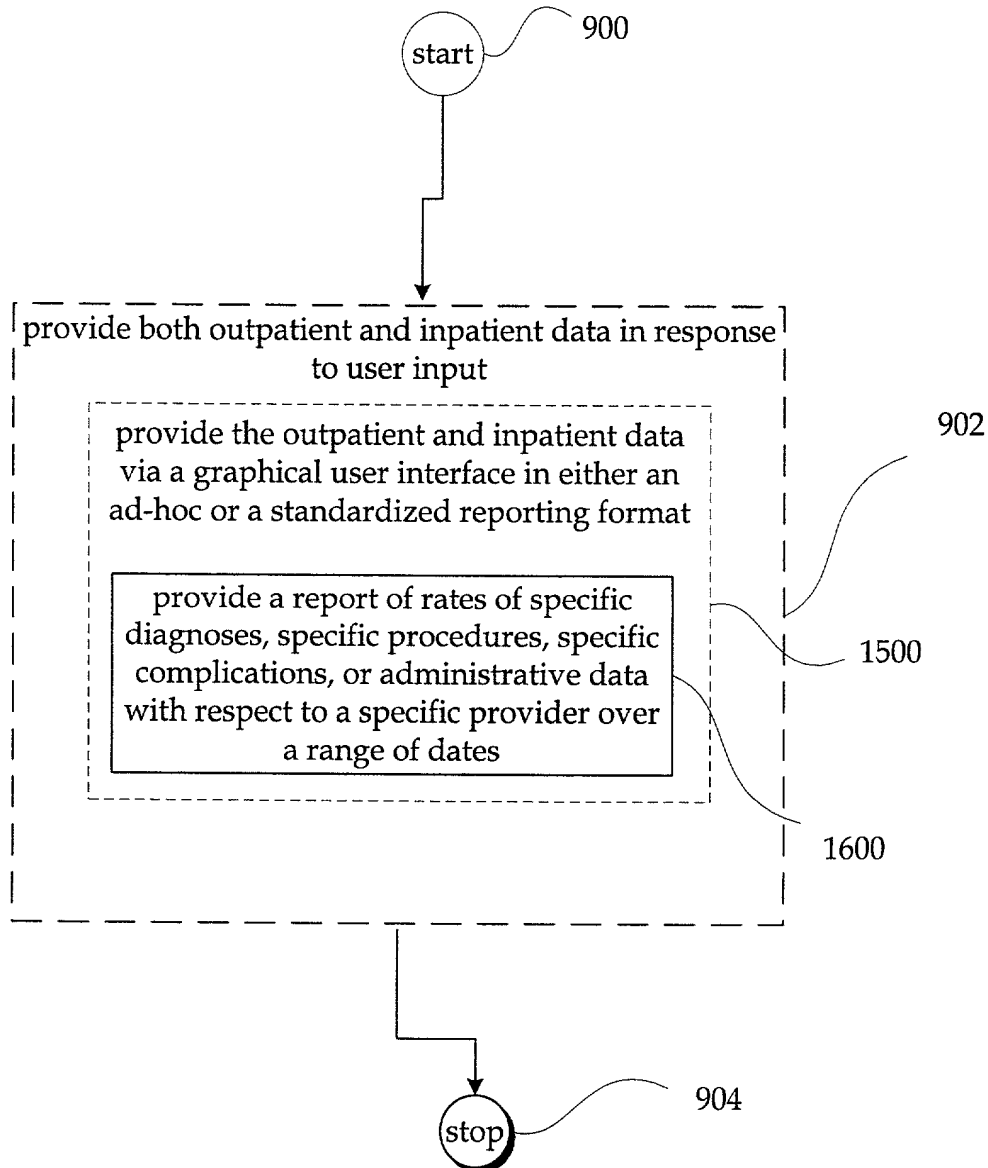
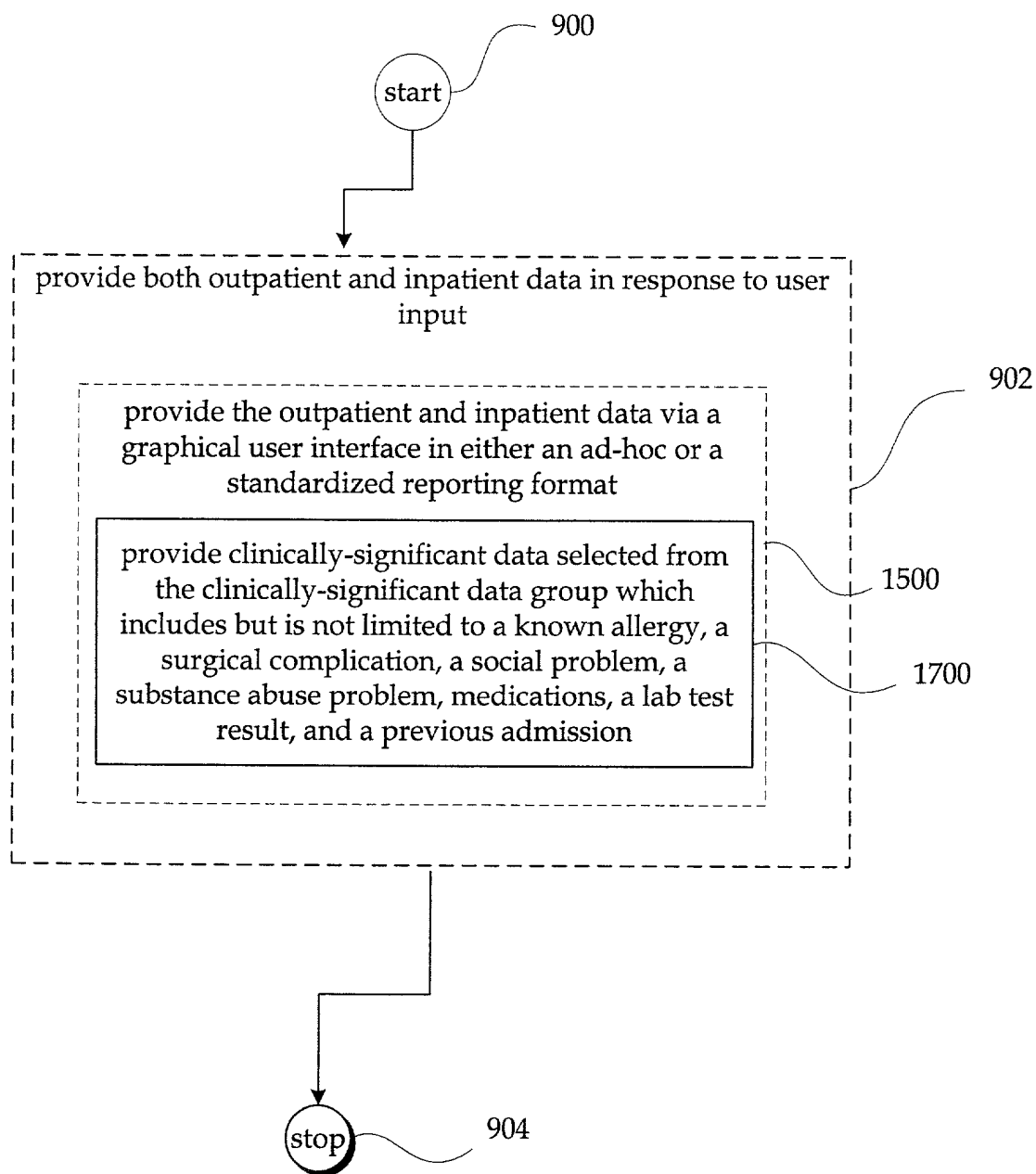


Fig. 16

*Fig. 17*

28/55

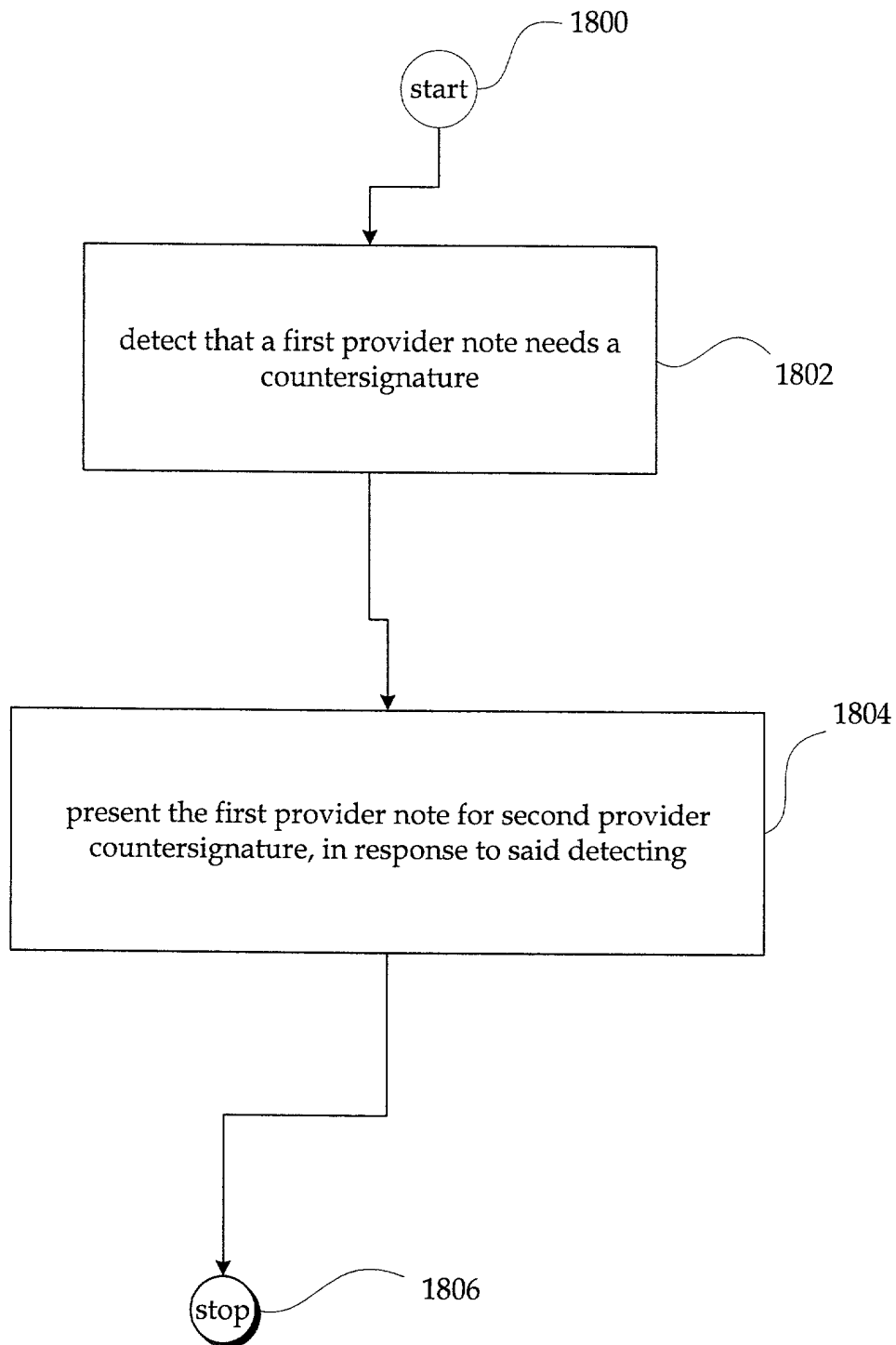


Fig. 18

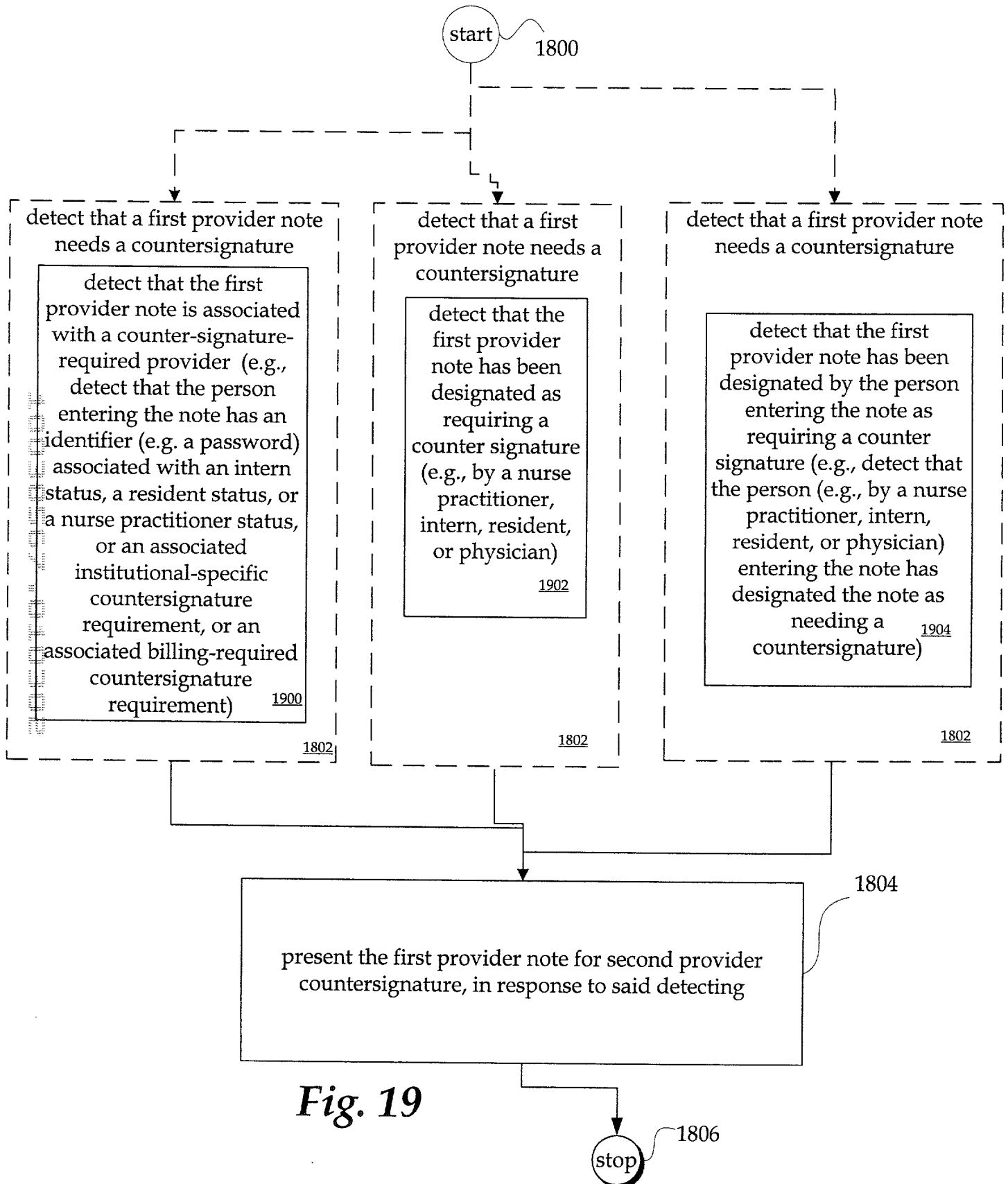


Fig. 19

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Labor and Delivery

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Progress Notes for Patient Name; Patient SSN **Disposition: PREGNANT**

UNASSIGNED Age: 32 G/P: 1/0-0-0-0 EDC: 30 Feb 2002 Gest Age: 28 6/7 Type/Rh: A- **STD LABS ALLERGIES**

Assoc Visit/Encounter: ROUTINE OB
New Phone Call/Consult: 17 Nov 2001 0800

Progress Notes View Existing Notes...

Progress Note Category: ANTEPARTUM NOTE Provider to Review Note: Doe, John A. Date the Note is for: optional

Standard Note Free Text/Addendum to Standard

Blank/Addendum Text: Test note

Next (Note: To clear the date, click in the field and press the Delete key.)

Critical? ☐ Yes ☒ No

Type ☐ Inpatient ☒ Outpatient

View Entire Note Save/Close Save Cancel Reset Help

Office

Start Slide Inbo CD Inbo... @CHC @CHC PW... RE Micr... ST... 3:34 PM

1950

1952

Fig. 19A

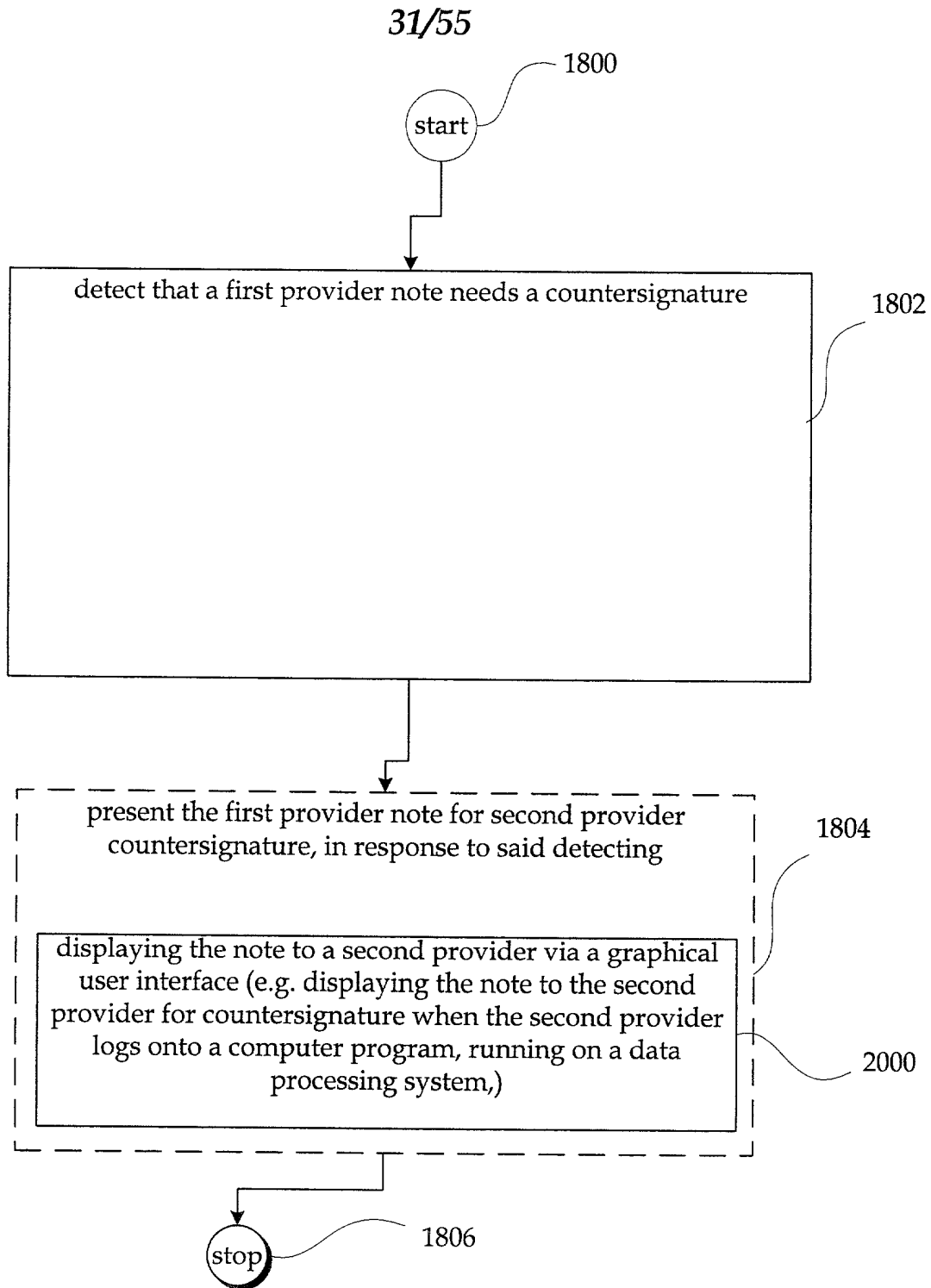


Fig. 20

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Open Patient Chart

A Search Criteria

☐ 1. Specific Patient (Last Name:)
☐ 2. All current patients with risk
☐ 3. Patients who have not delivered, but are admitted to
☐ 4. Patients who have delivered, but have not been discharged
☐ 5. Patients who have been discharged, but still need follow-up phone call
☐ 6. Patients who delivered on: to
☐ 7. Patients seen from to by

☐ 8. Patients who have NOTES to be reviewed by
☐ 9. Patients who have ITEMS to be reviewed by

Search: Reset: Print:

B Search Results

P	Patient Name (Last, First MI)	EMP	Sponsor SSN	Grav	Para	Wks	Days	EDC Date	Delivery Date	Discharge Date	Discha
	Doe, Jane A.	20	111-11-111	1	0	38	0	06 Dec 2001	23 Nov 2001	25 Nov 2001	0900
	Doe, Jane B.	20	222-22-222	1	0	35	1	03 Jan 2002			
	Doe, Jane C.	20	333-33-333	1	0	19	6	20 Apr 2002			
	Doe, Jane D.	20	444-44-444	1	0	24	5	14 Mar 2002			

P = Physician Review for Delivery Info (* = Needs to be reviewed)

Total patients matching search criteria: 30 Feb

New Patient/Preg New Pregnancy FlowSheet Notes OB Clinic L and D Postpartum Discharge Follow-Up

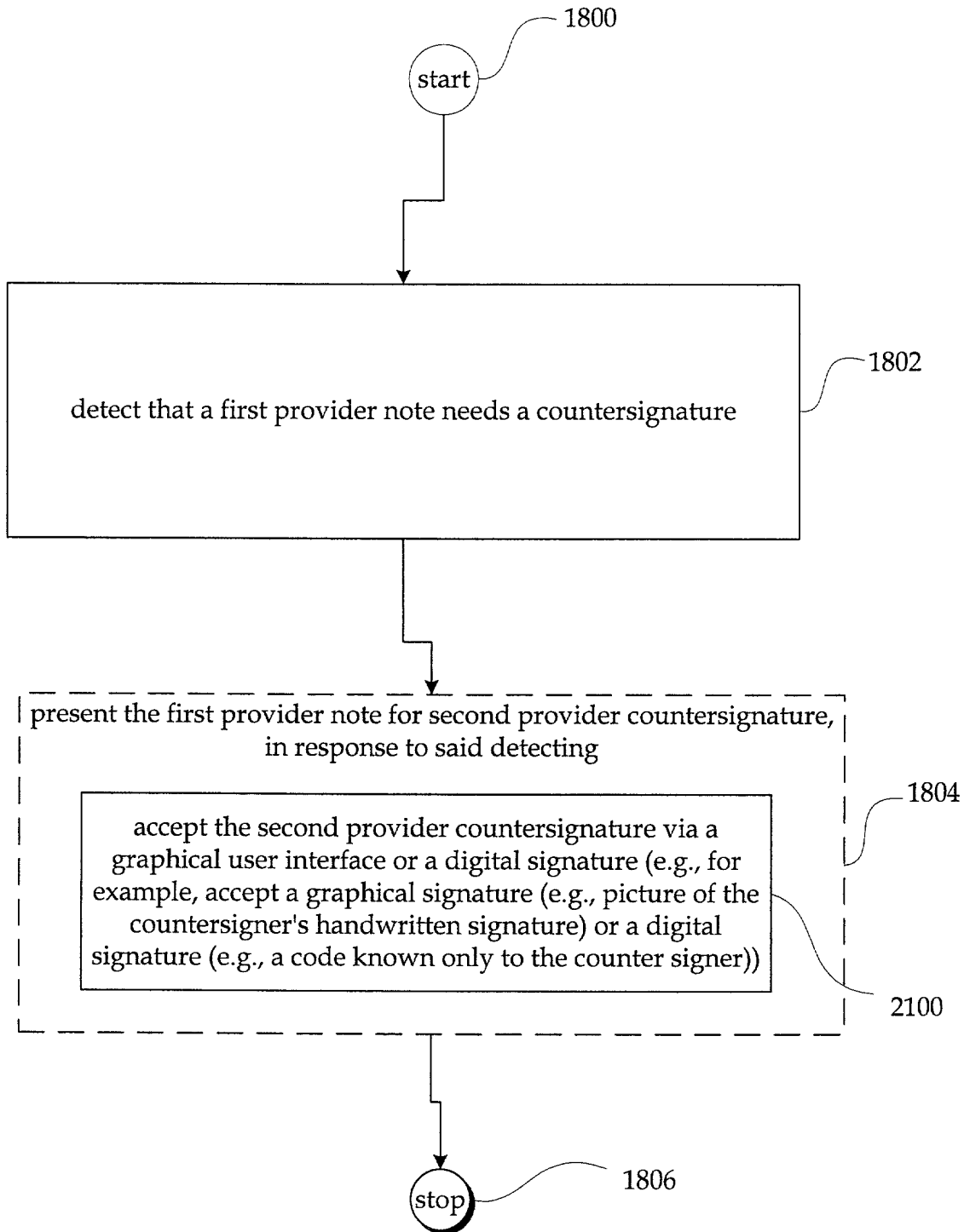
Office

Start Slide Inbox CD PI STORC Inbox CHCS CHCS PA C RE S 1:55 PM

2050

2052

Fig. 20A

*Fig. 21*

34/55

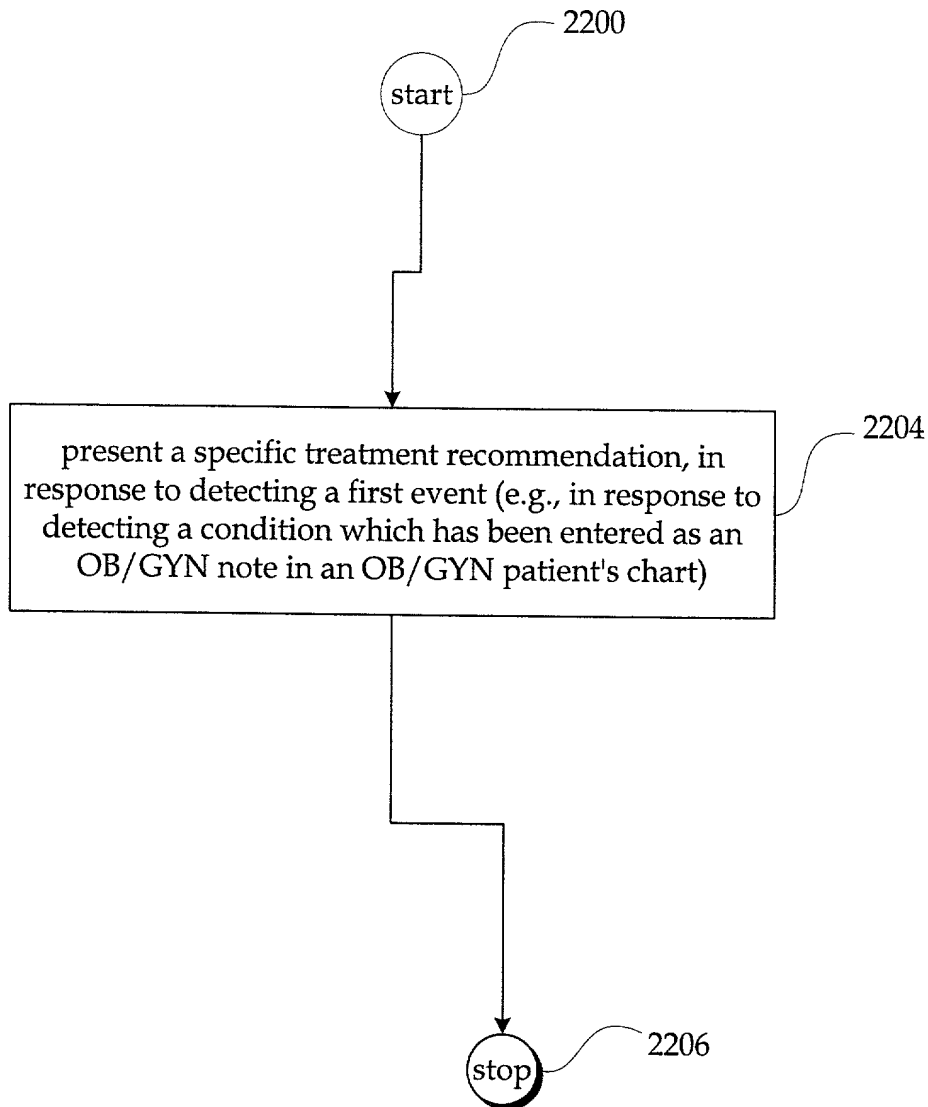


Fig. 22

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Labor and Delivery

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

ROB/COB Detailed Visit Information for Patient Name; Patient SSN Disposition: PREGNANT

LOW Age: 20 G/P: 2/0-0-1-0 EDD: 08 Mar 2002 Gest Age: 17 1/7 Type/Rh: O+ STD LABS NKDA

Detailed OB Visit Information

Subjective Objective Assessment/Plan

Assessment

Assessment (Health Condition/Diagnosis)	Pb List?	Plan (Dbl Click)	R/O?	Comment	Add
OBESITY	<input type="checkbox"/>		<input type="checkbox"/>		
ROB. UNCOMPLICATED	<input type="checkbox"/>		<input type="checkbox"/>		Delete
MASTITIS, PREGNANCY	<input type="checkbox"/>		<input type="checkbox"/>		

ROB COB Next

Patient Specific Assessment(s)

Plans

Standard Plan/Remark	Entered By	Entered Date	Del
Standard Plan for 15 - 19 wks	drmann	17 Nov 2001 1408	

Add Plan Delete...

Patient Specific Plan(s)

Offered Triple Screen, RTC in 4-6 weeks. Note quickening
RX with Dicloxicillin

View Existing Notes OK Cancel Reset Help

Office

Start Slid... Inbo... CD... Inbo... CHC... CHC... FW... RE... Mic... ST... 3:25 PM

Fig. 22A

STORC Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: OB Clinic

Key Info General Visits Physical History Cerv Exams Demo Tests US Proce Meds Compl Pb List Notes

ROB/COB Detailed Visit Information for Patient Name; Patient SSN Disposition: PREGNANT

UNASSIGNED Age: 37 G/P: 3/1-0-1-1 EDC: 08 Mar 2001 Gest Age: 31-5/7 Type/Rhv: B+ STD LABS NKCA

Detailed OB Visit Information

Subjective Objective Assessment/Plan

ROB Visit COB Visit Next

Assessment

Assessment (Health Condition/Diagnosis)	Pb List?	Plan (Dbl Click)	R/D?	Comment	Add
ADVANCED MATERNAL AGE	<input type="checkbox"/>		<input type="checkbox"/>		
ANEMIA	<input type="checkbox"/>		<input type="checkbox"/>		Delete
ROB, UNCOMPLICATED	<input type="checkbox"/>		<input type="checkbox"/>		ROB

Patient-Specific Assessment(s):

Plans

Standard Plan/Remark	Entered By	Entered Date	Del	Add Plan
Standard Plan for > 28 wks and < 36 wks	drmann	24 Nov 2001 1103		

Patient-Specific Plan(s):

Preterm Labor Precautions, RTC in 2 weeks, Daily Fetal Kick Counts recommended, Breast feeding class encouraged, Signs/symptoms of preeclampsia reviewed, Preadmit if not yet done

View Existing Notes OK Cancel Reset Help

Office

Start Slide Inboxes CD Inboxes CHC CHC RE Mic ST... 3:12 PM

2254

2250

2256

Fig. 22B

37/55

2252

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: OB Clinic

Key Info General Visits Physical History Cerv Exam Demo Tests US Procs Meds Compl Pb List Notes

ROB/COB Detailed Visit Information for Patient Name; Patient SSN Disposition: ADMITTED

COMPLICATED Age: 22 G/P: 1/0-0-0-0 EDC: 19 Mar 2001 Gest Age: 41 4/7 Type/Rh: A- STD LABS ALLERGIES

Detailed OB Visit Information

ROB Visit COB Visit Next

Subjective Objective Assessment/Plan

Assessment

Assessment (Health Condition/Diagnosis)	Pb List?	Plan (Dbl Click)	R/O?	Comment	Add
ANEMIA	<input type="checkbox"/>		<input type="checkbox"/>		
CARDIAC DISEASE, SPECIFY	<input type="checkbox"/>		<input type="checkbox"/>	Recommended right arm and right leg B/Ps each visit	Delete
RH NEGATIVE	<input type="checkbox"/>		<input type="checkbox"/>		
ROB, UNCOMPLICATED	<input type="checkbox"/>		<input type="checkbox"/>		

ROB COB

Patient-Specific Assessment(s):

Plans

Standard Plan/Remark	Entered By	Entered Date	Del
Standard Plan for >= 41 wks	drmann	27 Nov 2001 1012	

Add Plan Delete Std

Patient-Specific Plan(s):

Labor Precautions, Daily Fetal Kick Counts recommended, RTC in 1 week, NST/AFI 2X/wk, Consider induction

View Existing Notes OK Cancel Reset Help

Office

Start Stop Info ED Info CHC CHC PW RE Micr ST 3:27 PM

2254

2250

2256

Fig. 22C

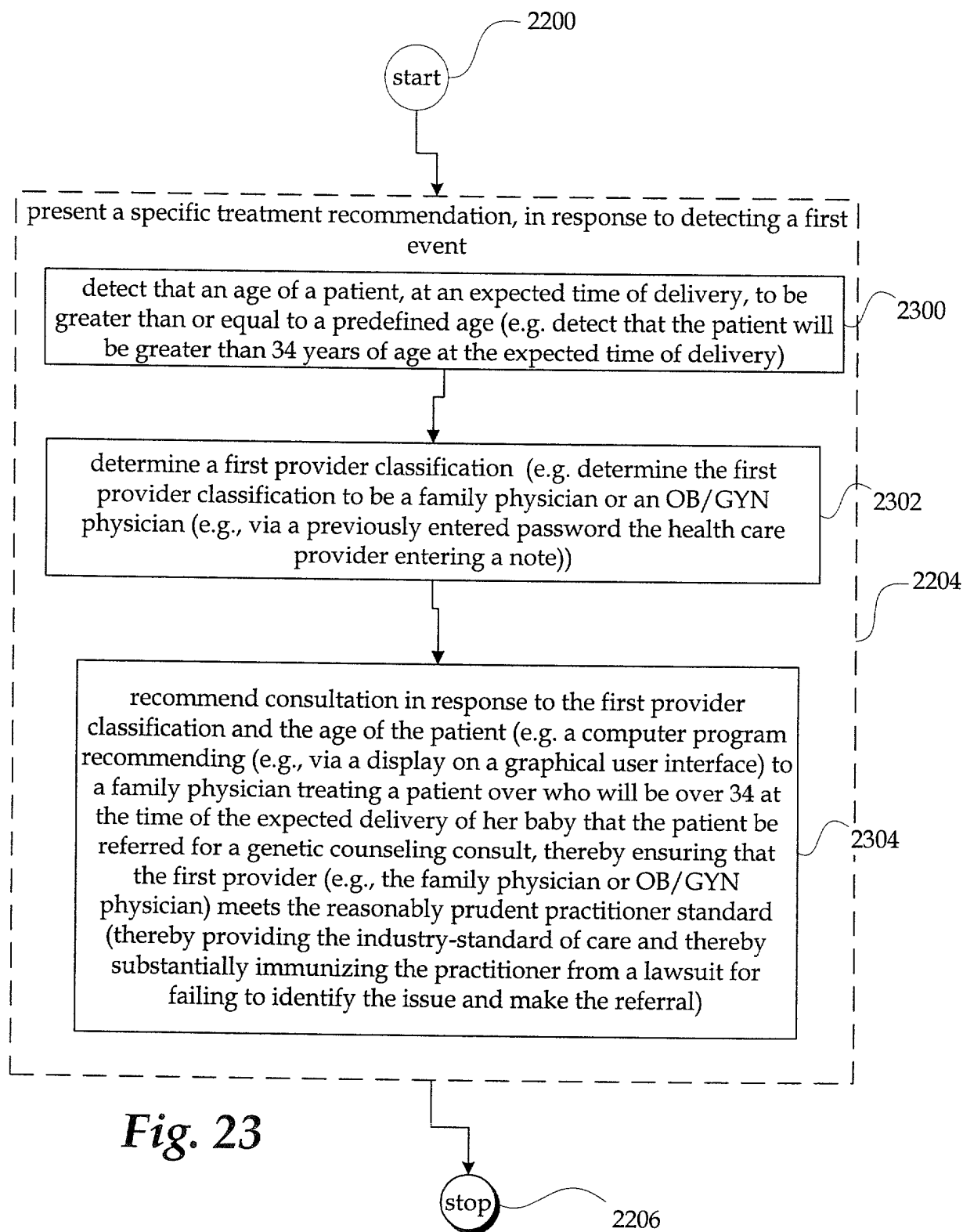
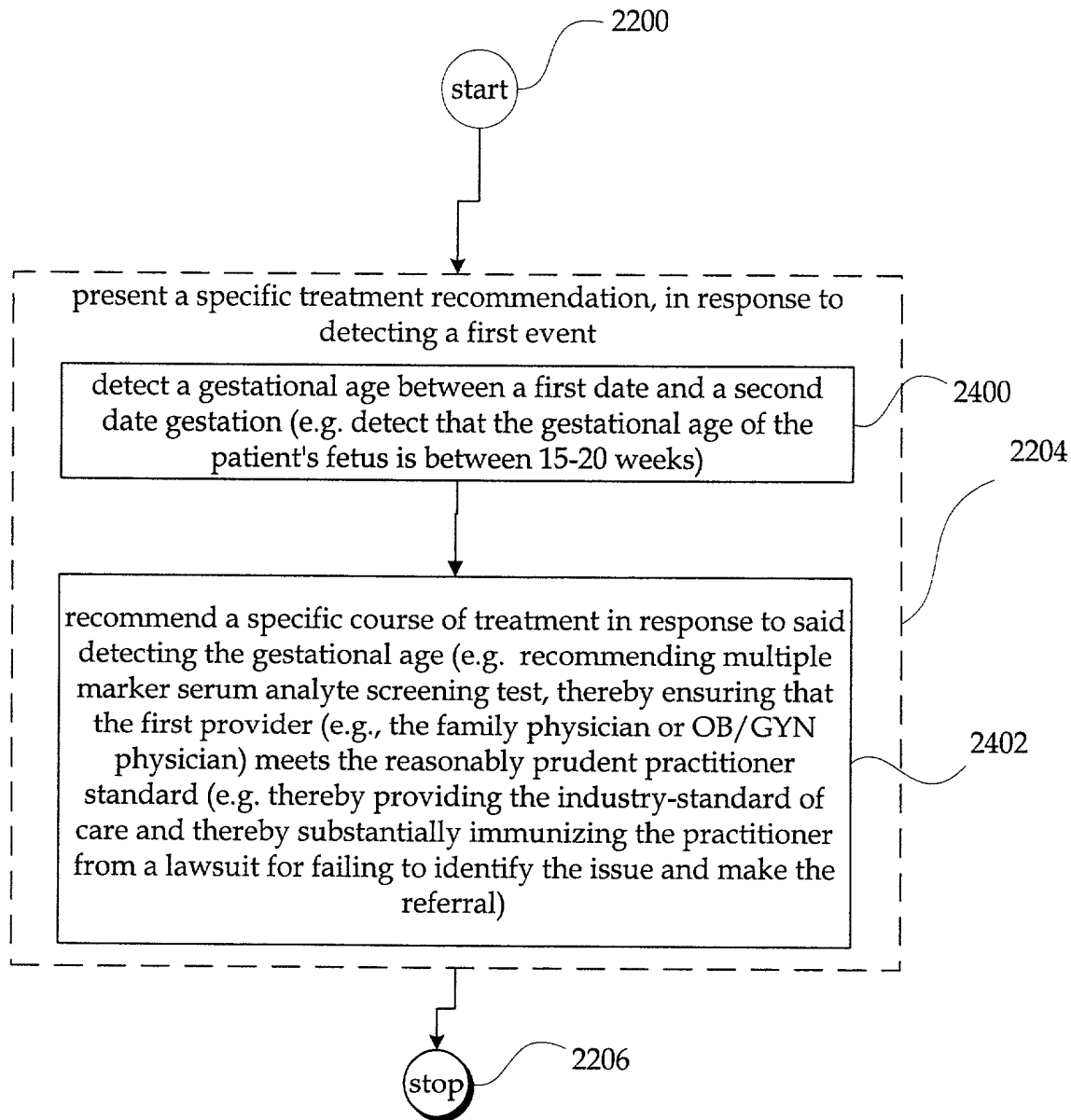


Fig. 23

*Fig. 24*

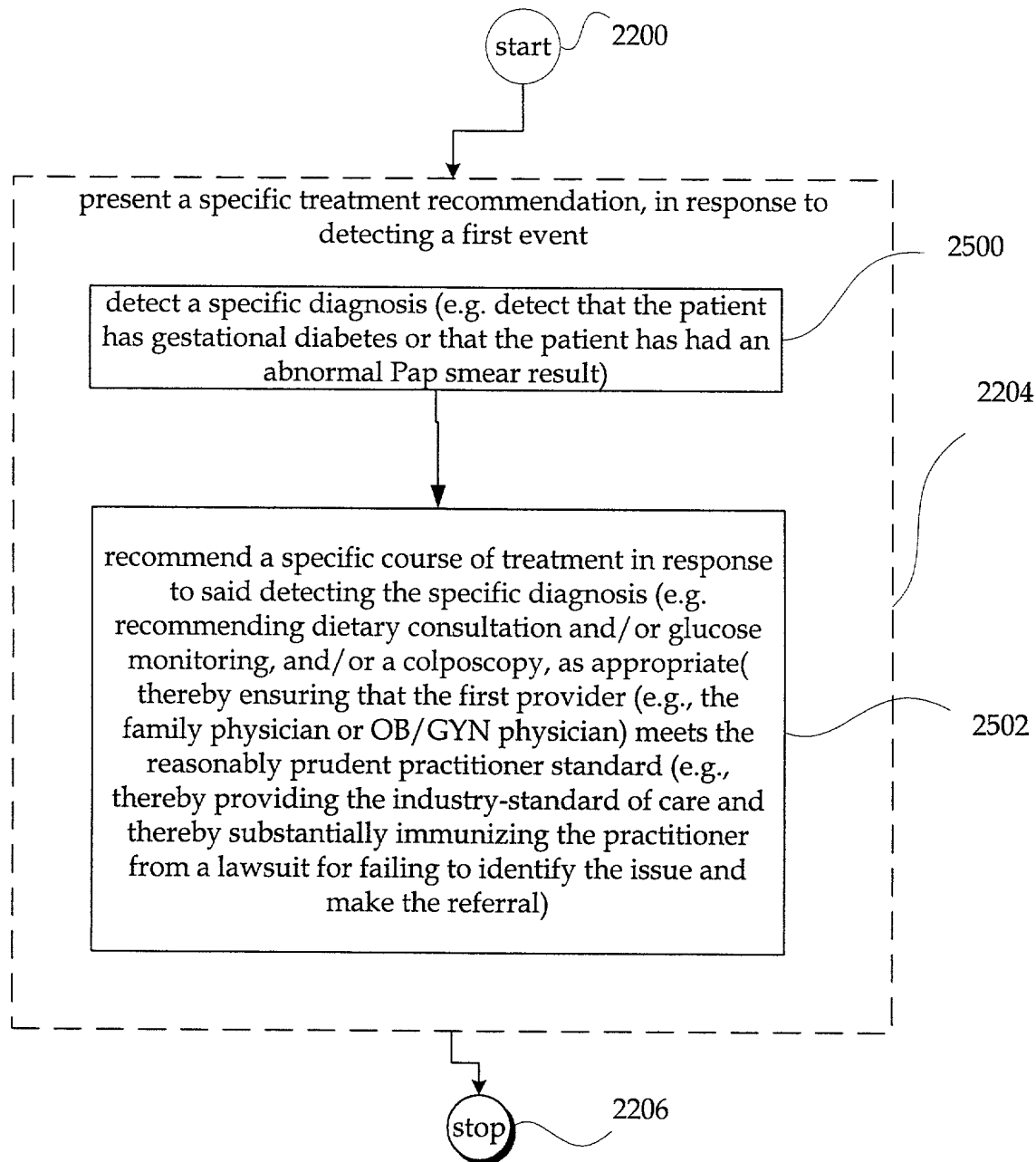
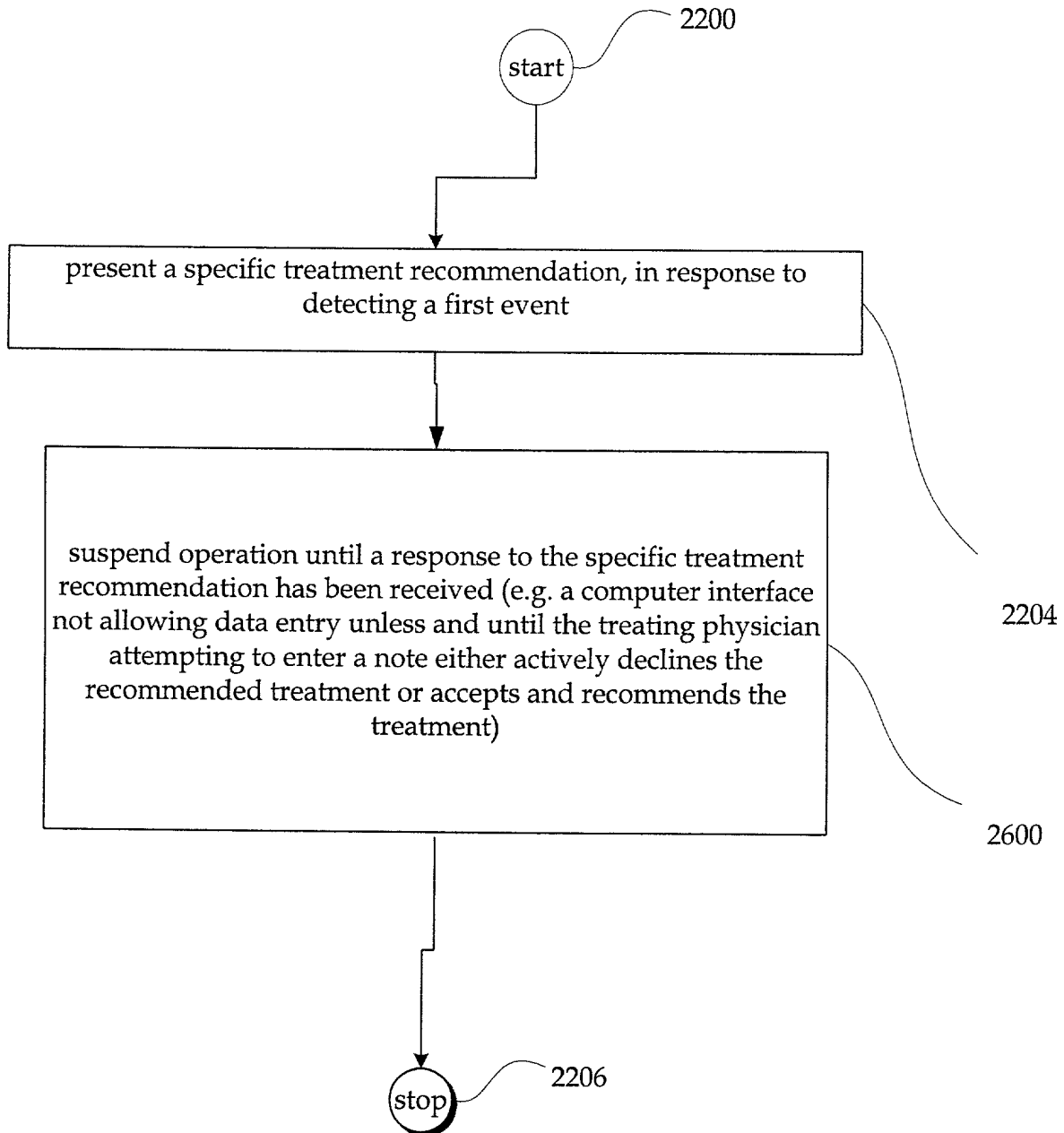


Fig. 25

*Fig. 26*

42/55

TCRC - Standard Obstetrical Record Charting System

File View Tools Windows Help

Functional Area: Labor and Delivery

Key Info General Visits Adm History Exams Delivery Discharge Demo Tests US Procs Meds Compl Pb List Notes

Admission for Patient Name; Patient SSN Disposition: PRETERM

COMPLICATED Age G/P: 3/0/1/1/0 EDC: 10 Feb 2002 Gest Age: 29 5/7 Type/Rh: STD LABS REVIEW

Admissions

General Info Complaints/Exams Impressions/Plans Additional Comments Date/Time of Selected Admission: 30 Nov 2001 0800

Impression: **GBS Prophylaxis**

Standard Imp: Specific criteria has been met that may warrant GBS PROPHYLAXIS. Do you wish to add this to the plan for the patient?

PRETERM L: This message is displayed if ANY of the following conditions exist for the patient at the time of admission and the GBS Prophylaxis plan has not been selected already for the patient for this admission:

1. < 37 weeks gestation
2. Temperature > 100.4
3. Rupture of membranes > 18 hours
4. Problem list with previous h/o group B strep -OR- GBS infection in this pregnancy

Patient-Spect: Explanation (required if you choose not to add GBS Prophylaxis to the plan)

Plans

Standard Pla: ADMIT TO L

Add to Plan Do Not Add to Plan Cancel

Delete

Mark Reviewed/Save/Close Save/Close Save Cancel Help

Office

Start Slide Inbox CD PL Inbox CHCS CHCS PW RE S STG 2:09 PM

2650

2652

Fig. 26A

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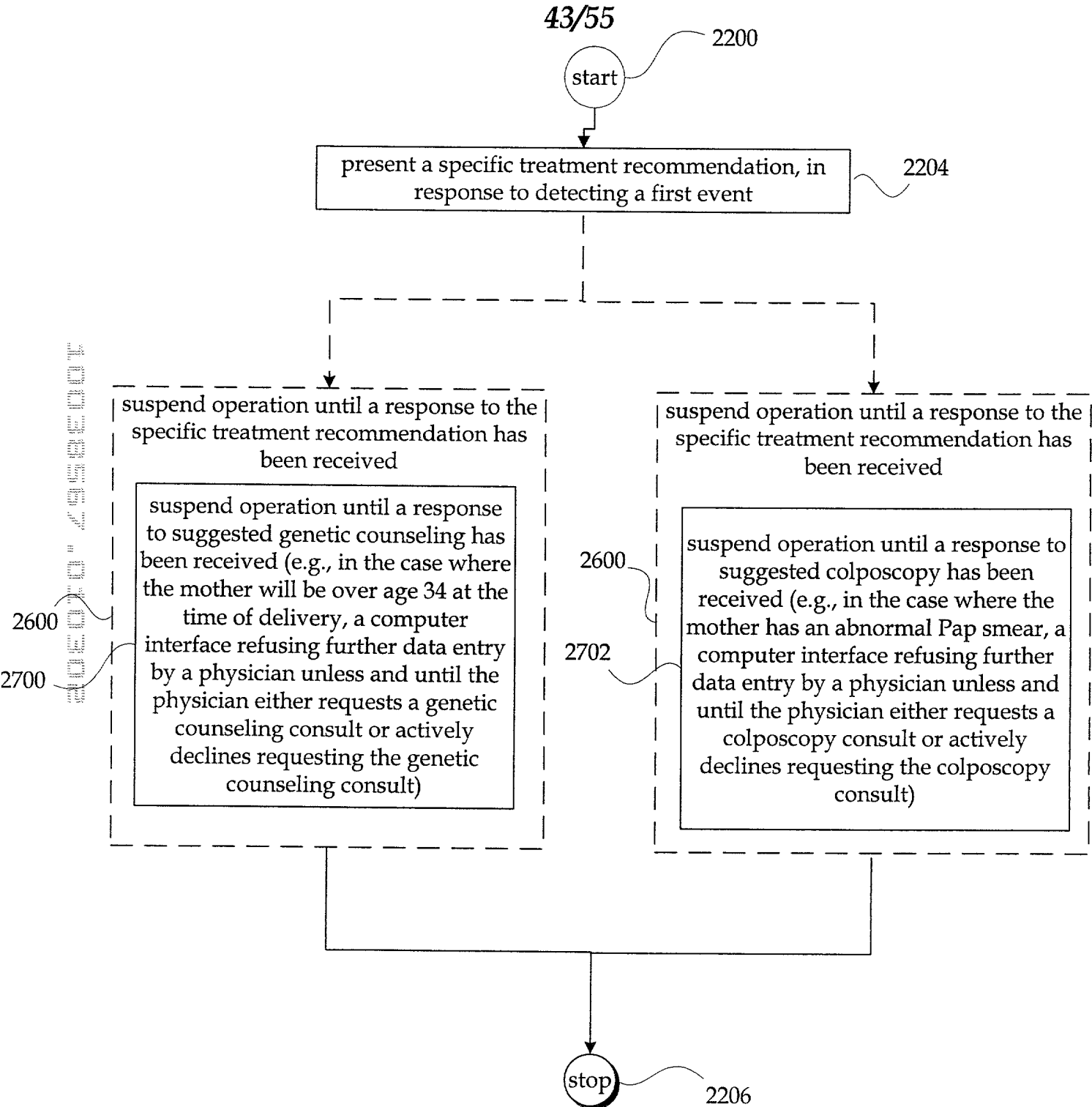


Fig. 27

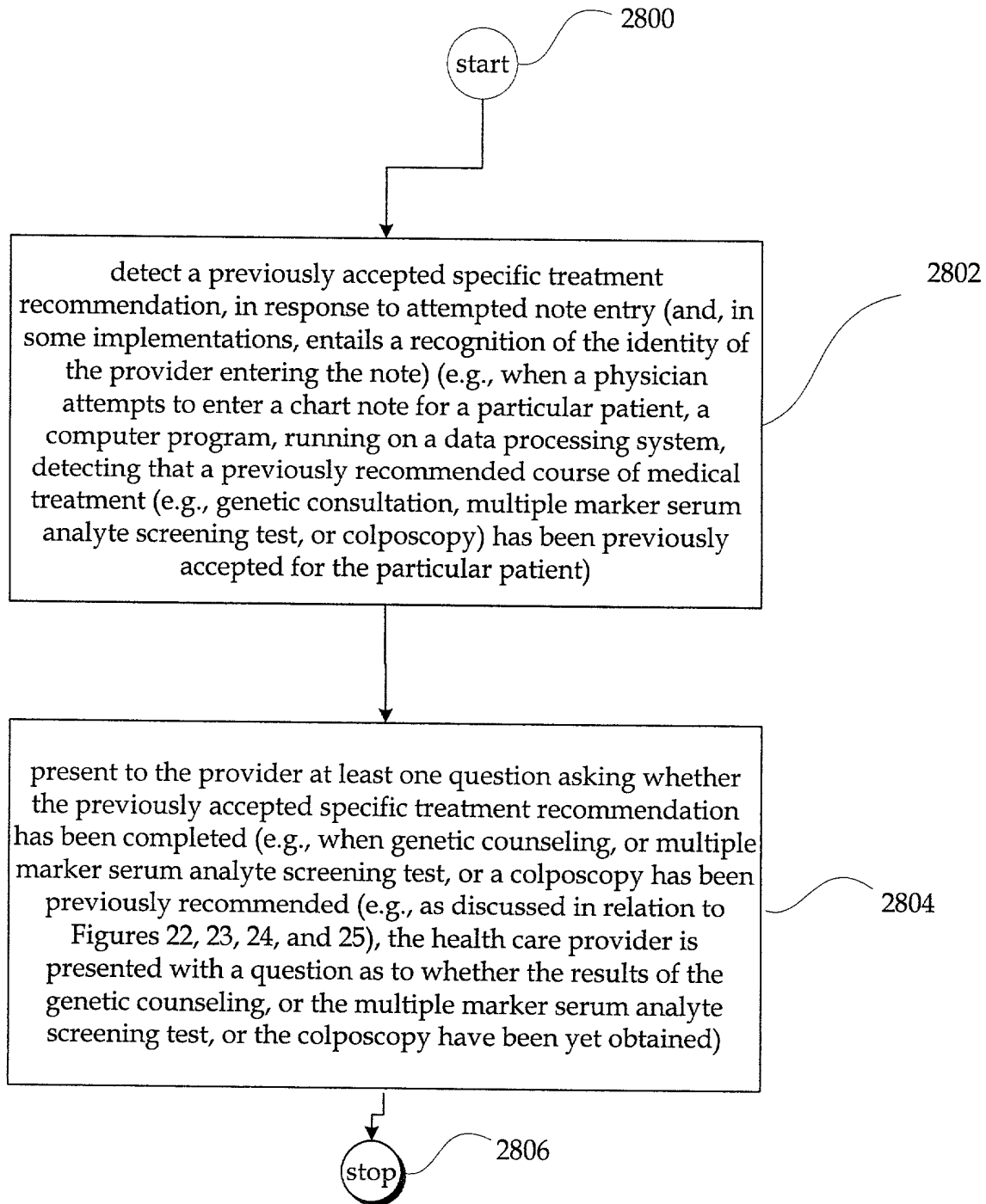


Fig. 28

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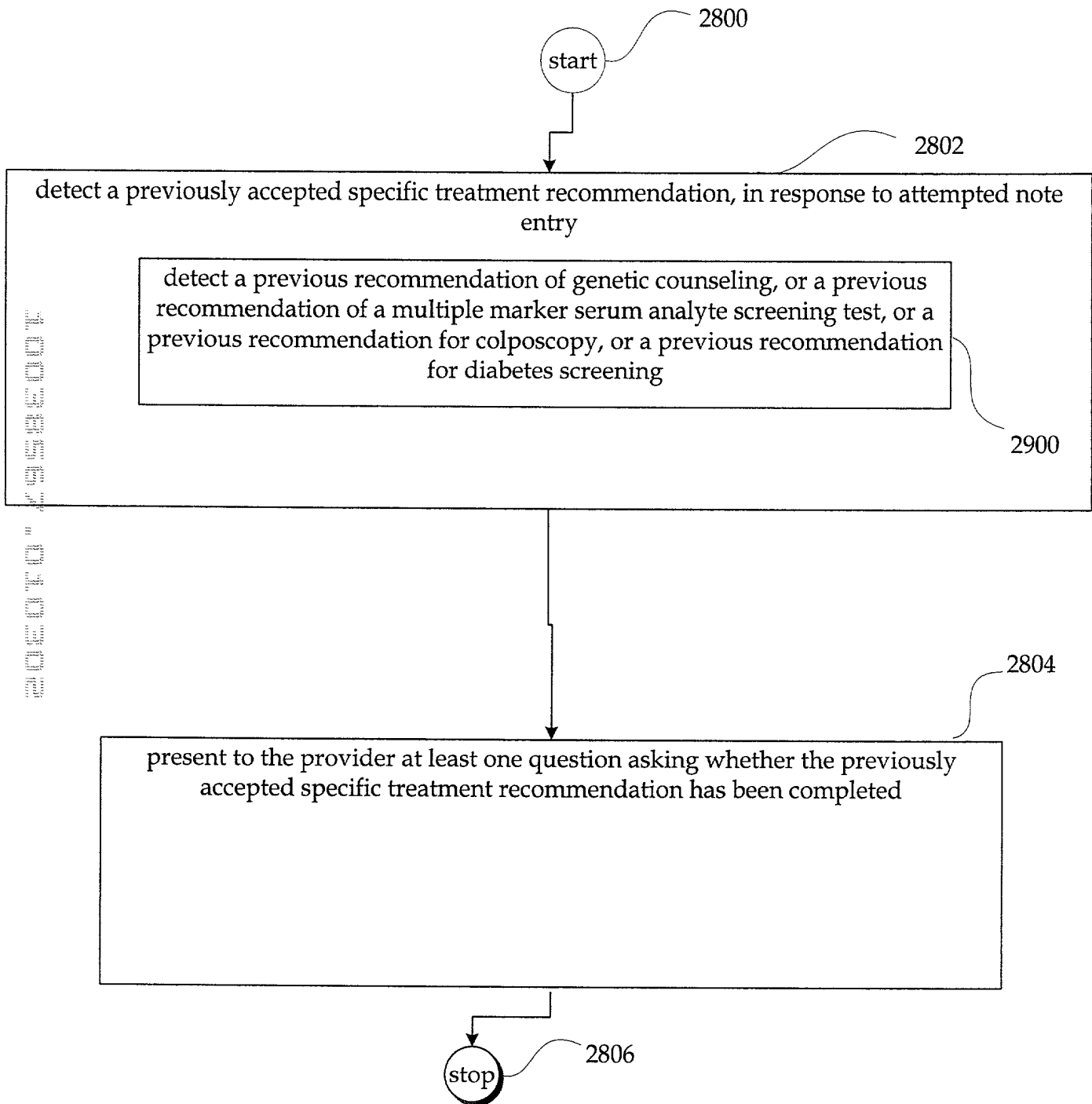


Fig. 29

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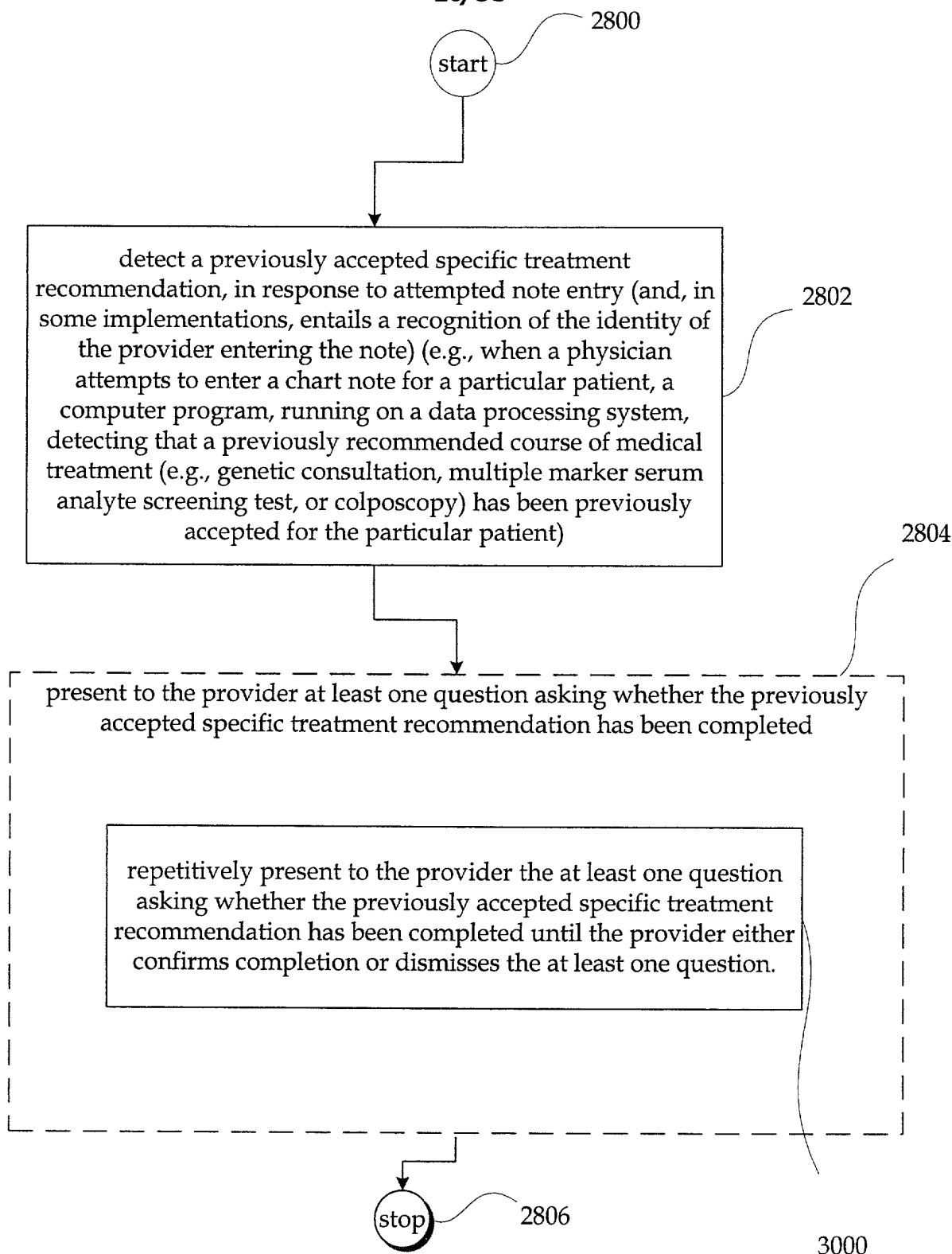


Fig. 30

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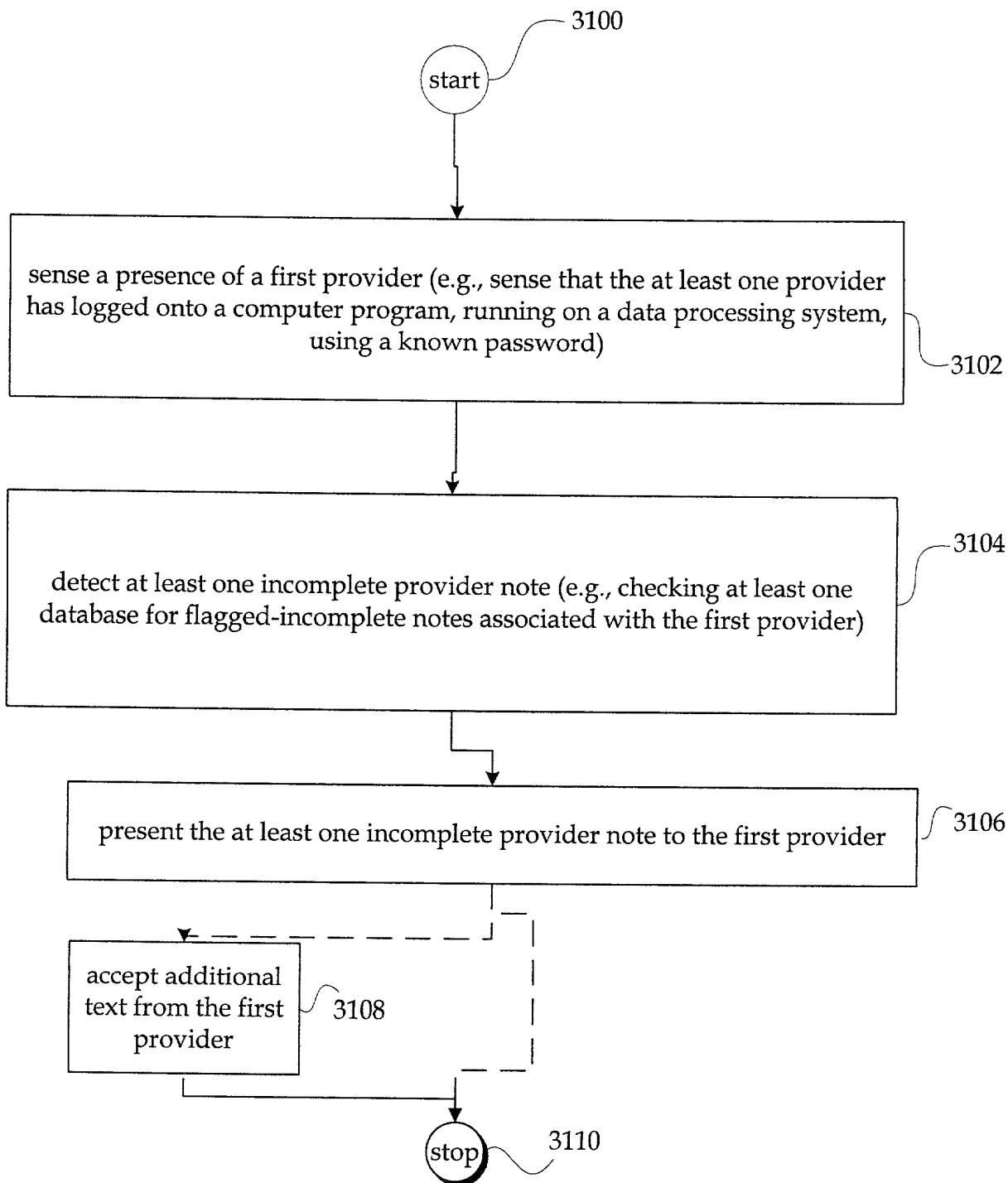


Fig. 31

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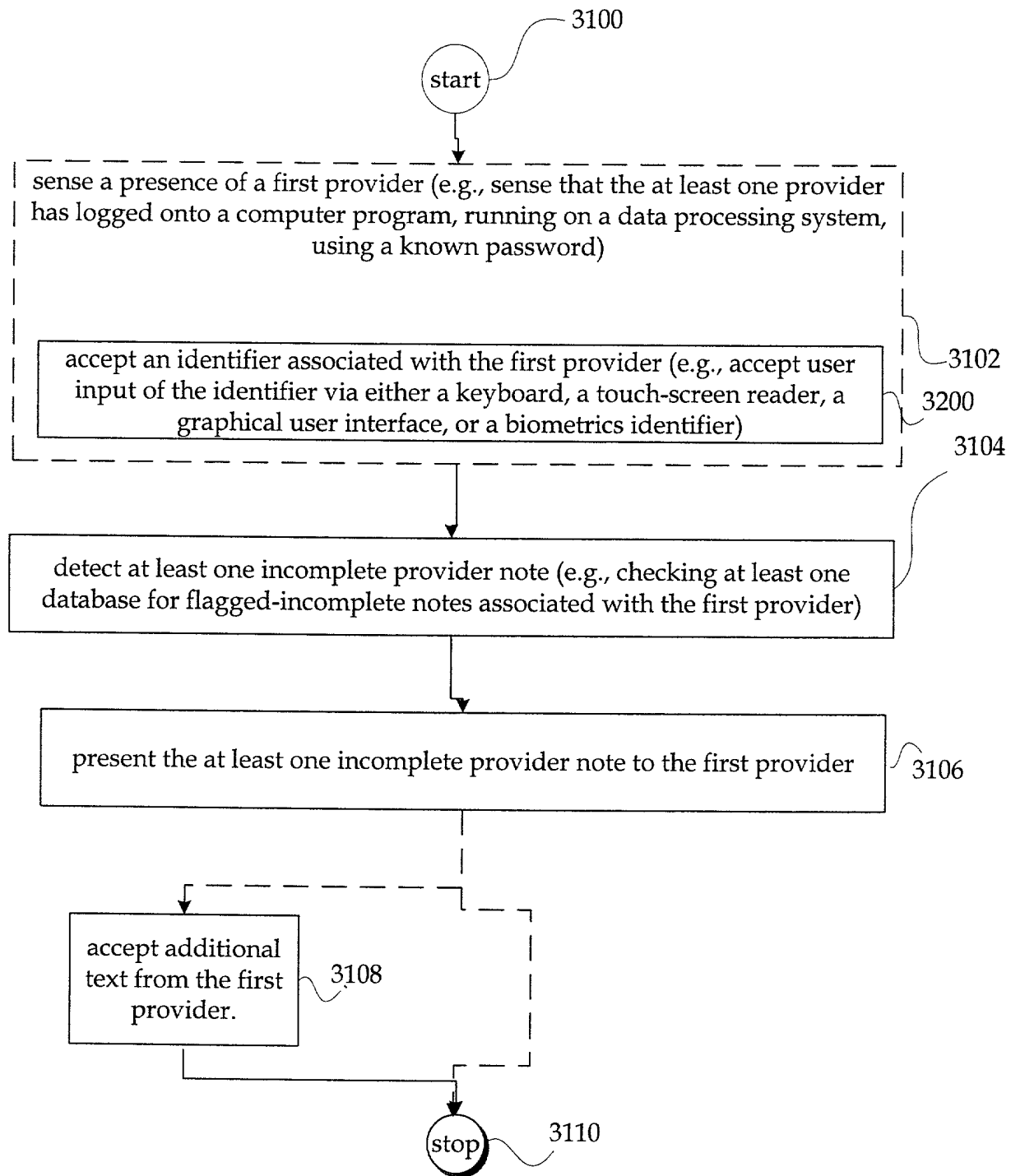
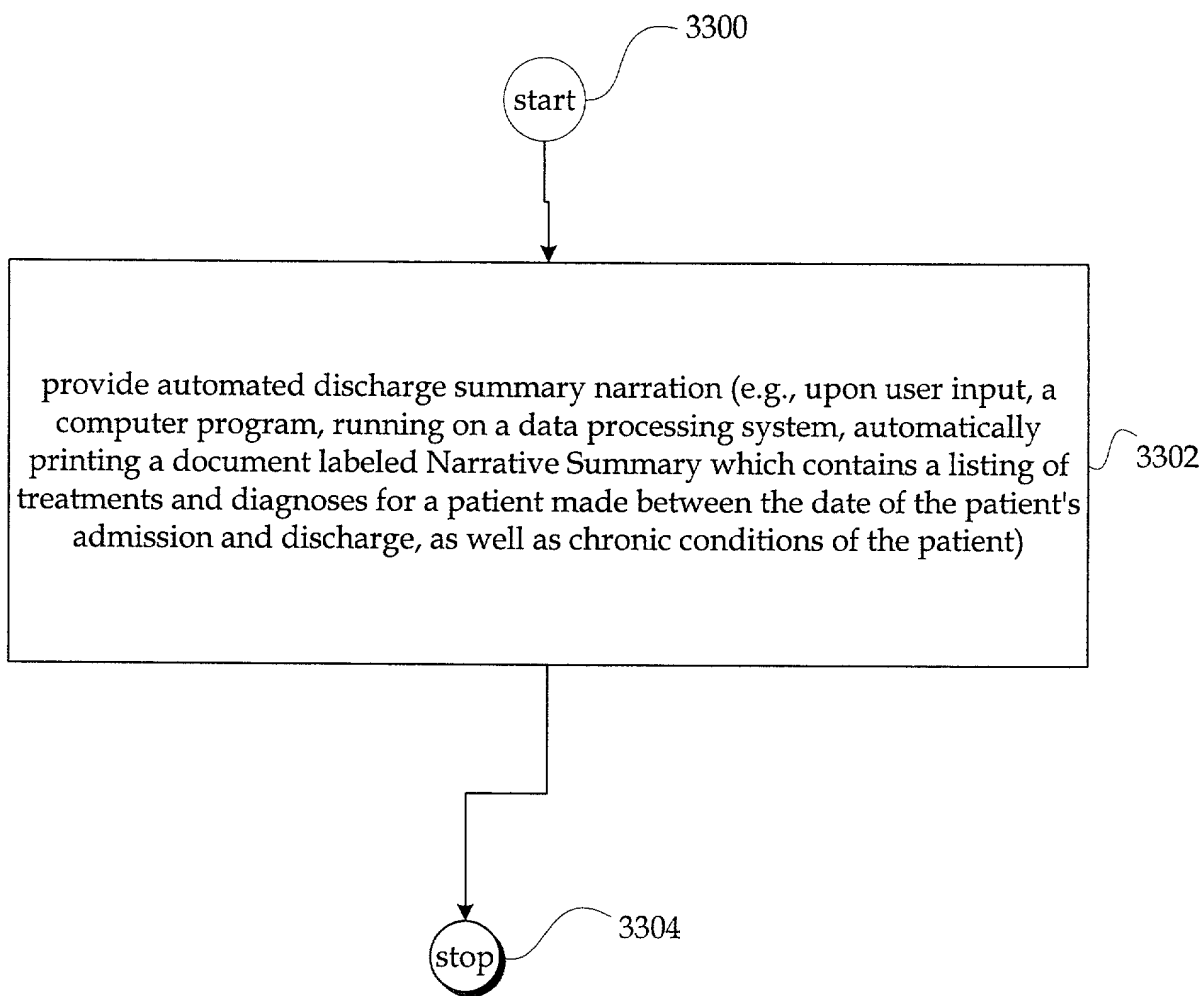


Fig. 32

*Fig. 33*

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STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 0/7 Type/Rh: A+ STD LABS NKDA

Discharge Summary

Refresh Findings/Diag/Procs Next

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

Prior Admissions/Discharges

Admit Date	Disch Date	Review Date/Time	Re
23 Nov 2001	23 Nov 2001	23 Nov 2001 0900	ev

Delete Discharge... Total: 1

Discharge Date: 25 Nov 2001 Time: 0900 Discharging Phys: drmann

Admission Complaint/Reason(s) Comment

RUPTURE OF MEMBRANES

Final Diagnosis Summary: (This will show as delivered if there is a Stage 3 Date)

38 week/0 day IUP, delivered 1 Liveborn, FEMALE weighing 3560 gms with apgar scores of 8/9 Delivery via SVD

Procedures Performed:

- AUGMENTATION OF LABOR, OXYTOCIN
- EPIDURAL
- FENTANYL
- FETAL SCALP ELECTRODE
- FOLEY PLACEMENT
- INTRATHECAL ANESTHESIA
- MIDLINE EPISIOTOMY

(Note: If delivery was an Extrauterine Pregnancy and it is shown as an IUP, you must add Extrauterine Pregnancy to the Pb List or Compl screen and then click Refresh)

Doc Screen... Mark Reviewed/Save/Close Save/Close Save Cancel Repeat Print Help

Office

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Fig. 33A

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STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Best Age: 38 0/7 Type/Rh: A+ STD LABS NKDA

Discharge Summary

Refresh Findings/Diag/Procs New

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

Significant Findings From Admission:

Finding/Health Condition	Type	Comment
CEPHALIC PRESENTATION	PRESENTATION	
LABOR, LATENT	ADMISSION	
NO LACERATION	LACERATION	
SROM (SPONTANEOUS RUPTURE OF VAGINAL DELIVERY)	ADMISSION	
	DELIVERY TYPE	

Note: To add/delete items for the significant findings and procedures lists, use the Problem List, Complication, and/or Procedure screens.

Office

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Fig. 33B

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/P: 1/00-0-0 EDC: 06 Dec 2001 Gest Age: 38 0/17 Type/Rh: A+ STD LABS NKDA

Discharge Summary Refresh Findings/Diag/Procs Next

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

Significant/Chronic Findings from History:

Finding/Health Condition	Type	Comment
ADVANCED MATERNAL AGE	ANTEPARTUM	
ADVANCED MATERNAL AGE	HISTORY GENERAL	
ADVANCED MATERNAL AGE	VISIT ASSESSMENT	
LEEP	ANTEPARTUM	SURGICAL Hx - Cervix > 4 cm on 4/26/01
SINGLE PARENT ACTIVE DUTY	ANTEPARTUM	No plan of marriage-FDB - min involved
STERILIZATION, DESIRED	ANTEPARTUM	

Note: To add/delete items for the significant findings and procedures lists, use the Problem List, Complication, and/or Procedure screens.

Occ Screen Mark Reviewed/Save/Close Save/Close Save Cancel Help

Office Microsoft

Start Slide Inbo CD Inbo CHC CHC FW RE Mic ST 2:16 PM

Fig. 33C

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/P: 170.0 0.0 EDC: 06 Dec 2001 Gest Age: 38 0/7 Type/Rh: A+ STD LABS NKDA

Discharge Summary

Refresh Findings/Diag/Procs Next

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

Discharge Medications

Medication/Drug Name	Entered By	23
VITAMIN PRENATAL (PNV)	ewhiggin	23
Motrin (Ibuprofen)	ewhiggin	23
Colace	ewhiggin	23
Iron	ewhiggin	23

Add Standard Meds

Other Instructions Select Site Instruction NSVD Comp VD C/S PTL Previa

Pelvic rest (no intercourse or douches) for 4-6 weeks
 Return for evaluation of temperature > 100.5, bleeding > menses, vomiting, pain, foul discharge
 Pericare for episiotomy if applicable
 Avoid tub bathing for 2 weeks
 Return to gentle exercise/activity in 2 weeks as tolerated

(Note: The Condition, Limitation and Diet values will be set to the appropriate defaults when one of the std instructions is selected.)

Condition on Discharge: STABLE, DELIVERED

Limitations on Activities: PELVIC REST FOR 4 - 6 WEEKS

Diet: REGULAR Narrative Summary Dictated? Yes No

Follow-Up Instructions

Return to: RAMSTEIN Facility

OB/GYN Clinic

In: 6 Weeks Days

Dec Screen Mark Reviewed/Save/Close Save/Close Save Cancel Help

Office

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2:17 PM

Fig. 33D

54/55

STORC - Standard Obstetrics Record Charting System

File View Tools Windows Help

Functional Area: Discharge

Key Info General Visits Adm History Exams Delivery EDP Discharge Demo Tests US Procs Meds Compl Pb List Notes

Discharge Information for Patient Name; Patient SSN Disposition: DELIVERED-CURRENT

COMPLICATED Age: 35 G/P: 1/0-0-0-0 EDC: 06 Dec 2001 Gest Age: 38 W: 7 Type/Rhr: A- STD LABS NKDA

Discharge Summary

Refresh Findings/Diag/Procs Next

Discharge Information Findings from Admission Findings from History Patient Instructions Discharge Comments

Enter any additional comments in the space provided below. If the comment can be recorded/entered elsewhere on one of the Discharge screens, you should use that space/method in order to make the data available for future analysis and research. (Maximum length of text is 255 characters)

Occ Screen Mark Reviewed/Save/Close Save/Close Save Cancel Help

Office

Start Slide Info EDC Info CHC CHC FW RE Micr ST... 2:18 PM

33E

ATTORNEY CLIENT PRIVILEGED AND/OR CONFIDENTIAL

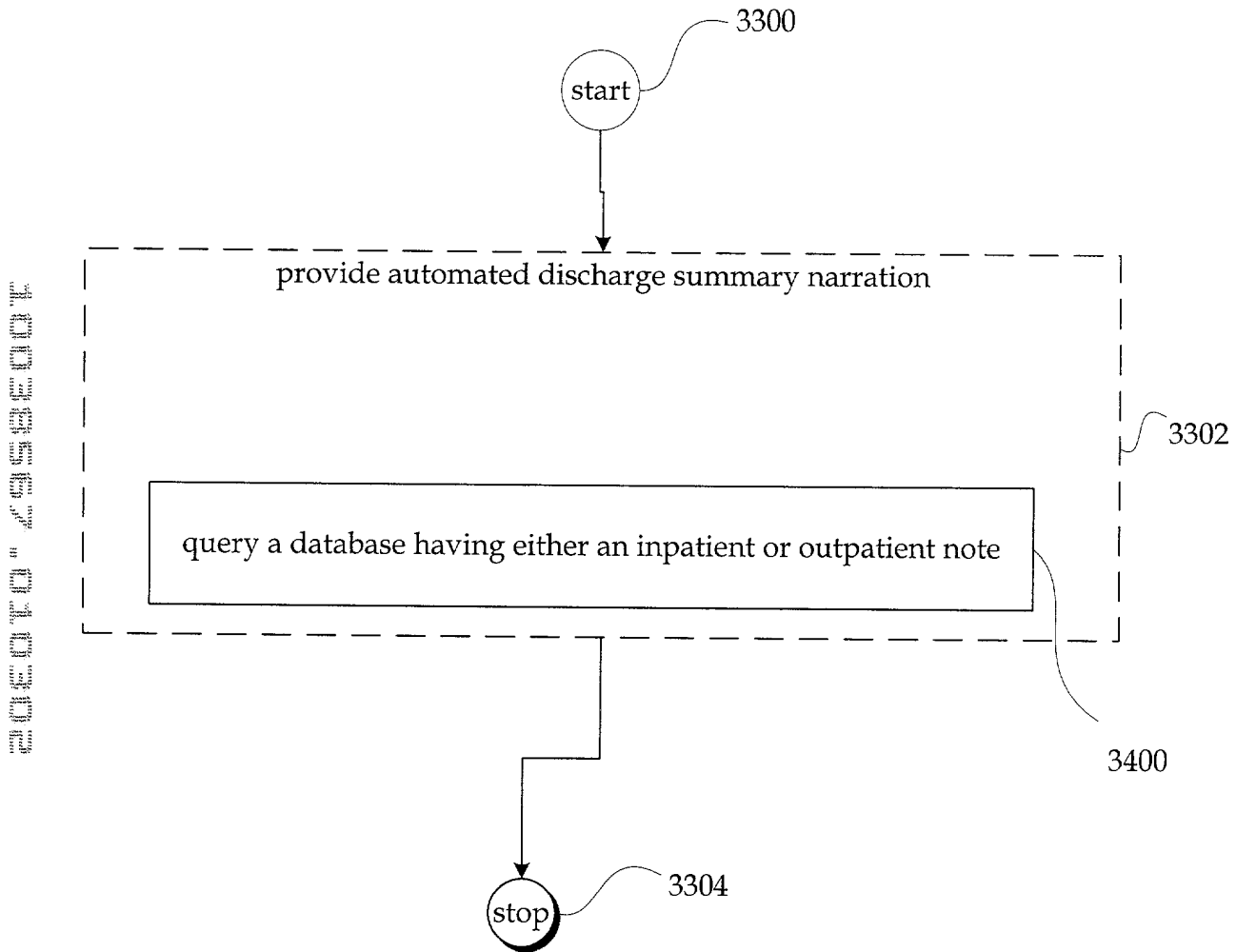


Fig. 34